CSAP's

Western

Center for the

Application of

Prevention

Technologies

Best and Promising Practices Substance Abuse Prevention

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CSAP's Western CAPT

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FOREWORD

The Center for Substance Abuse Prevention's Western Center for the Application of Prevention Technologies (CSAP's Western CAPT) is proud to provide *Best and Promising Practices for Substance Abuse Prevention* to the prevention community. The six regional CAPTs are funded by the Center for Substance Abuse Prevention to assist the prevention field in the application of science-based prevention strategies and programs. The *Best and Promising Practices for Substance Abuse Prevention* book is designed to assist in fulfilling this mission.

The CSAP's Western CAPT *Building a Successful Prevention Program* web site (http://www.open.org/~westcapt) forms the basis of the Best and Promising Practices for Substance Abuse Prevention book. Using criteria developed by researchers from a number of federal agencies, CSAP's Western CAPT has categorized prevention programs/strategies as "best," "promising," and "unproven." A variety of sources are used to identify prevention programs/strategies. Within these user-friendly pages and web site, prevention professionals search for scientifically-defensible prevention information across a number of variables; including risk factor, domain, age categories, ethnicity, and CSAP strategy. The Building a Successful Prevention Program "seven steps" process is also on this web site, allowing prevention providers to obtain state-of-the-art information in areas such as community readiness, needs assessment, best practices, and evaluation.

CSAP's Western CAPT produces this book primarily for those without Internet access, and certainly hopes the publication is found useful. Please note, however, the web site is updated on a regular basis and information within this book changes over time.

Please feel free to contact CSAP's Western CAPT office toll free at 888.734.7476 for information on other CSAP's Western CAPT products and services.

CSAP's Western CAPT extends special thanks to Kristen Reed Gabrielsen, CSAP's Western CAPT Associate Director; Susan K. Rupp, CSAP's Western CAPT Program Assistant; Mary Anne Crane, CSAP's Western CAPT Administrative Assistant; and Gretchen Casey, CSAP's Western CAPT Special Projects Coordinator for producing this document.

Julie Hogan, Ph.D., Director CSAP's Western CAPT

GUIDING PRINCIPLES, BEST PRACTICES AND PROMISING PRACTICES

What are guiding principles and best practices?

Best practices are those strategies, activities, or approaches that have been shown through research and evaluation to be effective at preventing and/or delaying substance abuse.

Guiding principles are recommendations on how to create effective prevention programs. When a community already has a prevention program or strategy in place, the guiding principles can be used to gauge the program's potential effectiveness. They can also be used to design an innovative program/strategy when none of the best practices are appropriate to the community's needs.

Before you select a best practice or apply the guiding principles, your community must conduct an assessment (risk assessment) to identify the risk and protective factors that need to be addressed in your community. Once you have identified which risk and protective factor(s) to address through your assessment, you can use the information in this book to select the best practice(s) and/or guiding principles to address your community's needs.

Definition of "best practice"

In this web site "best practices" are those strategies and programs that are deemed research-based by scientists and researchers by the following agencies:

National Institute on Drug Abuse (NIDA)

Center for Substance Abuse Prevention (CSAP)

National Center for the Advancement of Prevention (NCAP)

Office of Juvenile Justice and Delinquency Prevention (OJJDP)

Centers for Disease Control and Prevention (CDC)

These are strategies and programs that have been shown through substantial research and evaluation to be effective at preventing and/or delaying substance abuse. If you are familiar with the rating scale presented in the document, "Science-Based Practices in Substance Abuse Prevention: A Guide" prepared by P.J. Brounstein, J.M. Zweig, and S.E. Gardner, the best practices in this web site would fall into the categories of types 5, 4, and some 3.

Please Note: Each best practice has not been labeled either 3, 4, or 5. The authors of the document did not label each program with a number of 3, 4, or 5. Therefore, this information does not exist.

We have also included a category called "Promising Practices" in areas of the web site where there are few programs that have enough outcome data (or that have been sufficiently evaluated) to be deemed best practices.

Definition of "promising practices"

Promising practices are programs and strategies that have some quantitative data showing positive outcomes in delaying substance abuse over a period of time, but do not have enough research or replication to support generalizable outcomes. These practices would fall into the rating scale (mentioned above) of types 1, 2 and some 3.

Submitting your program for review

If you wish to have your program reviewed to be included as a best or promising practice, visit the following web site and click on "registry": http://www.preventionsystem.org

Note: No single best practice will be successful at preventing substance abuse in your community. To be as comprehensive as possible, best practices addressing prevention strategies (CSAP strategies) in all areas of your community (family, school, individual, peer, society/community) should be implemented. Remember: There is no single "magic" program in prevention!

PREVENTION PRINCIPLES FOR CHILDREN AND ADOLESCENTS

(Excerpt from Preventing Drug Use Among Children and Adolescents: A Research-Based Guide by the National Institute on Drug Abuse, 1997, pages i-ii)

The following principles can be applied to either existing programs to assess their potential effectiveness or used when designing innovative programs/strategies:

- Prevention programs should be designed to enhance protective factors and move toward reversing or reducing known risk factors.
- Prevention programs should target all forms of drug abuse, including the use of tobacco, alcohol, marijuana, and inhalants.
- Prevention programs should include skills to resist drugs when offered, strengthen personal commitments against drug use, and increase social competency (e.g., in communications, peer relationships, self-efficacy, and assertiveness) in conjunction with reinforcement of attitudes against drug use.
- Prevention programs for adolescents should include interactive methods, such as peer discussion groups, rather than didactic teaching techniques alone.
- Prevention programs should include a parents' or caregivers' component that reinforces what the children are learning - such as facts about drugs and their harmful effects - and that opens opportunities for family discussions about use of legal and illegal substances and family policies about their use.
- Prevention programs should be long-term, over the school career with repeat interventions to reinforce the original prevention goals. For example, school-based efforts directed at elementary and middle school students should include booster sessions to help with critical transitions from middle to high school.
- Family-focused prevention efforts have a greater impact than strategies that focus on parents only or children only.

- Community programs that include media campaigns and policy changes, such as new regulations that restrict access to alcohol, tobacco, or other drugs, are more effective when they are accompanied by school and family interventions.
- Community programs need to strengthen norms against drug use in all drug abuse prevention settings, including the family, the school and the community.
- Schools offer opportunities to reach all populations and also serve as important settings for specific sub-populations at risk for drug abuse, such as children with behavior problems or learning disabilities and those who are potential dropouts.
- Prevention programming should be adapted to address the specific nature of the drug abuse problem in the local community.
- The higher the level of risk of the target population, the more intensive the prevention effort must be and the earlier it must begin.
- Prevention programs should be age-specific, developmentally appropriate, and culturally sensitive.
- Effective prevention programs are cost-effective. For every dollar spent on drug use prevention, communities can save 4 to 5 dollars in costs for drug abuse treatment and counseling.

[To order a free copy of *Preventing Drug Use Among Children* and *Adolescents: A Research-Based Guide by the National Institute on Drug Abuse* (1997) contact SAMHSA's National Clearinghouse for Alcohol and Drug Information (NCADI):

Web site: http://ncadi.samhsa.gov

Phone: 800.729.6686

and request publication order no. "PHD 734"]



INTRODUCTION

Best Practices and Promising Practices Summaries

The following pages contain summaries of best practices and promising practices in alphabetical order. Included in each summary is a description of the program or strategy, the risk factors and protective factors it primarily addresses, the CSAP strategies used (explained in Appendix B), the Institute of Medicine classification (see Appendix H), recommendations on how to evaluate the program/strategy, research conclusions, cost, special considerations and contact information. In the appendices, the programs and strategies are cross-indexed according to these categories. Some program developers did not submit complete information. Consequently, please contact the developers directly for additional program information.

The programs and strategies listed in this book and on the related CSAP's Western CAPT web site (www.open.org/~westcapt) are examples of scientifically-defensible prevention efforts. While CSAP's Western CAPT does review prevention literature and periodically update the information, there are likely to be other proven practices that are not listed. Inclusion of a strategy or program in this document does not imply endorsement by the CSAP's Western CAPT nor by the Center for Substance Abuse Prevention.

The information in this volume is continually updated on the CSAP's Western CAPT web site. For information about new strategies or changes to this volume, please visit the web site at www.open.org/~westcapt, or call CSAP's Western CAPT staff toll free at 888.734.7476.

If you wish to have your program reviewed to be included as a best or promising practice, visit the National Prevention System web site and click on "registry,"

Web site: http://www.preventionsystem.org



Best Practices

BEST PRACTICE: Across Ages

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BEST PRACTICE: Across Ages

(CSAP Demonstration Grant #2779)

Description of Best Practice

(Excerpt from "Understanding Substance Abuse Prevention — Toward the 21st Century: A Primer on Effective Programs," Center for Substance Abuse Prevention, unpublished document.)

The Across Ages program included three components: elders mentoring youth, youth performing community service, and teacher training. The core of the program, mentoring, involved older adults (55+ years old) spending a minimum of four hours each week (two 2-hour sessions) with high-risk students assigned to them. Mentors met with students all year long, not just during the school year. Mentors were carefully recruited, screened, trained, and matched with one or two high-risk youth. Mentors were also carefully supervised by project staff, who also provided support.

Mentoring activities included: tutoring, assistance with school projects, recreational activities, attending cultural or sporting events, performing community service, or just time spent nurturing. Most of these activities took place out of the school setting.

The second focus of Across Ages was student service: Here, students performed community service by making biweekly visits of about an hour to institutionalized frail elderly. This activity, designed to break down age-related stereotypes among youth, also served to reinforce feelings of competence, teach self-confidence, improve self-concept, and instill a sense of social responsibility.

The third component of Across Ages was teacher training: Teachers were trained to administer to sixth graders the Social Problem Solving and Substance Abuse Prevention modules of the Positive Youth Development Curriculum (PYDC). The PYDC modules involve 26 lessons, taught at least once a week for about an hour, focusing on stress management, self-esteem, problem solving, substance and health information, as well as social networks and peer resistance skills.

Lastly, Across Ages offered a series of activities that provided the opportunity for positive interaction among parents, students, and mentors: meals, transportation, and incentives were offered to participating parents.

Taken together, these data demonstrate:

- the effectiveness of matching youth with older adults serving as mentors in improving pro-social values,
- increasing knowledge of the consequences of substance use, and
- engendering resilience to help youth avoid later substance use by teaching them appropriate resistance behaviors.

Risk Factors Addressed

Low commitment to school

Protective Factors Addressed

Bonding: School and people with healthy beliefs and

clear standards

Healthy beliefs and clear standards

Skills: Resistance skills

Opportunities: Community service

CSAP Strategies

Information dissemination Education Alternatives

Type of Strategy

Selective

Populations Appropriate for This Best Practice

- 6th Grade
- African American
- Asian
- Hispanic
- Caucasian

Evaluating This Best Practice

This best practice comes with an evaluation tool, Across Ages Evaluation Protocol, that can be used when implementing this strategy.

Evaluation Tool Cost: \$25.

The following are suggested areas to assess when implementing this practice:

- Assess increased knowledge of community service and more positive attitudes toward people and the future
- Assess number of days absent from school and attitudes toward school

Research Conclusions

(Excerpt from "Understanding Substance Abuse Prevention – Toward the 21st Century: A Primer on Effective Programs," Center for Substance Abuse Prevention, unpublished document.)

The data (gathered from this demonstration) demonstrate the effectiveness of matching youth with older adults serving as mentors in improving:

- Pro-social values
- Increasing knowledge of the consequences of substance use
- Engendering resilience to help youth avoid later substance use by teaching them appropriate resistance behaviors.

Costs as of May 2001 (Subject to Change)

Training Time is two days.

Training Costs: \$1000 per day, plus travel and per diem.

- This model is for program replication; it is not a trainthe-trainers model.
- Providers may become educated about the model in a shorter training that is not sufficient for implementation.
- Easily understood, Across Ages is more complex in implementation than it appears.

Technical Assistance Costs:

On-site, \$500 per day plus travel and per diem; telephone, \$30 per hour.

Strategy Implementation:

\$1,500 to \$2,000 per child for 12 months. These figures include the following:

At least one full-time staff member, mentor stipends or activity fund, cost of covering background checks for mentors, curriculum materials for life skills, Across Ages program development manual and mentor training materials, materials and activity costs for mentor-youth activities, community service activities and family events, transportation, office costs.

Special Considerations

Please consider the following before selecting this strategy for your community:

- Partnerships and collaboration with community organizations
- Cultural issues around mentoring
- Access to older adults in the community who will serve as mentors
- Community site for program activities
- Target population of youth from a specific location
- Awareness of ageism on the part of project staff, families and youth

Contact Information

For more information on this program, visit web site: http://modelprograms.samhsa.gov

For training, technical assistance, and materials, visit the following web site:

http://www.temple.edu/CIL/

Or contact:

Andrea Taylor, Ph.D. Temple University Center for Intergenerational Learning 1601 N. Broad Street, USB 206 Philadelphia, PA 19122

E-mail: andreat46@aol.com

Phone: 215.204.6708 Fax: 215.204.6733

BEST PRACTICE: Adolescent Alcohol Prevention Trial

(Donaldson et al)

Description of Best Practice

The Adolescent Alcohol Prevention Trial is not replicable. See below for details.

AAPT was a research project conducted by William Hansen. It included a universal classroom program designed for fifth grade students, with booster sessions conducted in the seventh grade. It included two primary strategies: resistance skills training designed to give children the social and behavioral skills they need to refuse explicit drug offers, and normative education specifically designed to combat the influences of passive social pressures and social modeling effects. It focused on correcting erroneous perceptions about the prevalence and acceptability of substance use and on establishing conservative group norms.

AAPT was a research project, not a program. Consequently, it is not possible to replicate AAPT. However, William Hansen took the part of AAPT that was identified as effective, and created the program, All Stars. The All Stars Program is replicable, with training and materials available.

Risk Factors Addressed

Favorable attitudes toward drug use Friends who use

Protective Factors Addressed

Healthy beliefs and clear standards Skills: Social and behavioral

CSAP Strategies

Information dissemination, education

Type of Strategy

Universal

Populations Appropriate for This Best Practice

Fifth and seventh grades

Evaluating This Best Practice

The following are suggested areas to assess when implementing this practice:

- · Assess decreased use of alcohol, tobacco and marijuana
- Assess change in favorable attitudes toward drug use
- · Assess social and behavioral skills gained

Research Conclusions

(Excerpt from Preventing Drug Use Among Children and Adolescents: A Research-Based Guide, National Institute on Drug Abuse, 1997, page 22.)

- In the research design, the students received either information about consequences of drug use only, resistance skills only, normative education only, or resistance skills training in combination with normative education.
- Results showed that the combination of resistance skills training and normative education prevented drug use; resistance skills training alone was not sufficient.

Costs and Special Considerations

Not applicable

Contact Information

AAPT is not replicable. Please review All Stars for the program that was developed from AAPT.

For questions about AAPT, contact: William B. Hansen, Ph.D.

7017 Albert Pick Road, Suite D Greensboro, NC 27409

E-mail: billhansen@tanglewood.net

Phone: 800.826.4539 Fax: 336.662.0099

BEST PRACTICE: Adolescent Transitions Program

(Dishion et al)

Description of Best Practice

(Excerpt from Preventing Drug Use Among Children and Adolescents, National Institute on Drug Abuse, 1997, pages 28-

The ATP is a school-based program that focuses on parenting practices and integrates the universal, selective, and indicated approaches for middle and junior high school interventions within a comprehensive framework. The universal level of the ATP strategy, directed to the parents of all students in a school, establishes a Family Resource Room. The goal, through collaboration with the school staff, is to engage parents, establish norms for parenting practices, and disseminate information about risks for problem behavior and substance use. The videotape "Parenting in the Teenage Years" helps parents identify observable risk factors and focuses on the use of effective and ineffective family management skills, including positive reinforcement, monitoring, limit-setting, and relationship skills to facilitate evaluation of levels and areas of risk.

The selective level of intervention, the Family Check-Up, offers family assessment and professional support to identify those families at risk for problem behavior and substance use. The indicated level, the Parent Focus curriculum, provides direct professional support to parents for making the changes indicated by the Family Check-Up. Services may include behavioral family therapy, parenting groups, or case management services. Following this tiered strategy, a family in the indicated parenting intervention would have participated in a Family Check-up and received information from the school's Family Resource Room about risk factors for early substance use and parenting practices that reduce the risk of drug use for their children.

Risk Factors Addressed

Family conflict Family management problems

Protective Factors Addressed

Bonding: Family

CSAP Strategy

Information dissemination Education

Type of Strategy

Universal Selective Indicated

Populations Appropriate for This Best Practice

Middle and junior high school youth

Evaluating This Best Practice

The following are suggested areas to assess when implementing this practice:

- Determine whether family management skills were en-
- Determine decreases in parental stress

Research Conclusions

(Excerpt from Preventing Drug Use Among Children and Adolescents, National Institute on Drug Abuse, 1997, page 29.)

This program is based on a series of intervention trials which comprise the Parent Focus curriculum and other intervention strategies, including working with high-risk teens in groups (Teen Focus curriculum) and directed strategies involving videotapes and newsletters. The findings from these studies indicate that parent interventions are needed for youth at high risk to reduce escalation of drug use, and repeated booster sessions are needed throughout the period of risk. These interventions were especially important because it was found that youth at high risk should not be places together in groups because it can worsen problem behaviors including those related to school and drug use.

Costs and Special Considerations

Please inquire of the contacts below.

Contact Information

For training and technical assistance contact:

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2738 NE Broadway Portland, OR 97232

E-mail: katek@darkwing.uoregon.edu

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For an informational packet only, contact:

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For free preview of Adolescent Transitions, contact:

Independent Video Services Phone: 800.678.3455

BEST PRACTICE: All Stars Program 13

BEST PRACTICE: All Stars Program

Description of Best Practice

(Information provided by Tanglewood Research, May 2001.)

The All Stars Program comes in two formats: Middle School Classroom Format and Community-Based Format.

Each format:

- · Reinforces the belief that risky behaviors are not normal or acceptable by the adolescent's peer group
- Cultivates the belief that risky behaviors do not fit with the youth's personal ideals and future aspirations
- · Creates strong voluntary personal and public commitments to not participate in risky behaviors
- Strengthens relationships between the adolescent, social institutions, and significant adults
- Helps parent to listen to their children, communicate clear no-use expectations about alcohol and other drugs, and support their children in working towards positive life

Middle School Classroom Format

- Targets the first year of middle or junior high school
- For use by classroom teachers, law enforcement officials, prevention specialists, and school counselors
- Includes thirteen 45-minute interactive classroom sessions, one-on-one meetings and small group discussions, a parent component, and a public celebration at the end
- Provides a community relations and promotion package

Community-Based Format

- Targets youth, ages 11 to 14, in already-established groups within community settings (e.g. churches, after school programs, community centers, boys and girls clubs)
- For use by the adult leaders (professional or volunteer) of the youth group/setting
- Includes nine, one-hour interactive group sessions, oneon-one meetings, small group discussions, a parent component, and a public celebration at the end
- Provides a community relations and promotion package
- · Provides a method for continuously integrating preven-

Risk Factors Addressed

Favorable attitudes toward drug use

Protective Factors Addressed

Bonding with positive institutions Healthy beliefs and clear standards

CSAP Strategy

Information dissemination Education

Type of Strategy

Universal

Populations Appropriate for This Best Practice

Early adolescents between the ages of 10 and 15

Evaluating This Best Practice

This best practice comes with an evaluation tool that can be used when implementing this strategy.

Evaluation Tool Cost:

The survey instrument is free. Please call the contact phone number regarding analysis costs. Analysis will be free soon, upon development of a web site for completing online evalu-

The following are suggested areas to assess when implementing this practice:

- Assess participants' commitment to avoid risky behav-
- Assess participants' bonding to school, the group, and to another adult
- · Assess participants' normative beliefs
- Assess participants' perception that risky behaviors would interfere with their future goals and ideals

Research Conclusions

(Excerpt from All Stars web site, www.tanglewood.net)

- All Stars students' commitment to avoid high-risk behavior significantly improved
- All Stars students' increased their bonding to school
- All Stars students' viewed high-risk behavior to be less accepted
- All Stars students' continued to view their lifestyle to be incongruent with high-risk behaviors

Costs as of December 2001 (Subject to Change)

Training Time: Two days

Training Costs:

- Option 1 Individual attending a scheduled training: \$250 per person plus travel expenses \$100 per person for facilitator curriculum
- Option 2 Group training (up to 20 participants): \$3,000 plus travel expenses for group training of 12 or more \$100 per person for facilitator curriculum

Strategy Implementation:

Please visit web site: http://www.tanglewood.net for current prices.

Special Considerations

Please consider the following before selecting this strategy for your community:

- Both program formats are ideally designed for either 6th or 7th grades with a booster program one year later.
- Both program formats target not just substance use, but also early sexual activity and violence.
- An elementary program for 4th and 5th grades is currently under development (ALL STARS Junior) as is a high school program for use in high school health courses (ALL STARS Senior).

Contact Information

For more information, visit web site: http://www.tanglewood.net

For technical assistance, training, or more information, contact:

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Lincoln, NE 68505

E-mail kathleensimley@alltel.net

Phone: 800.822.7148 Fax: 402.489.1072

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E-mail: billhansen@tanglewood.net

Phone: 800.826.4539 Fax: 336.662.0099

BEST PRACTICE: Athletes Training and Learning to Avoid Steroids: The ATLAS Program

(Goldberg et al)

Description of Best Practice

(Excerpt from Preventing Drug Use Among Children and Adolescents: A Research-Based Guide, National Institute on Drug Abuse, 1997, pages 23-24, and modified by Linn Goldberg of ATLAS in December 2001.)

ATLAS is a multi-component universal program for male high school athletes, designed to reduce risk factors for use of anabolic steroids and other drugs while providing healthy sports nutrition and strength-training alternatives to illicit use of athletic-enhancing substances. Coaches and peer teammates facilitate curriculum delivery with scripted manuals in small cooperative learning groups, taking advantage of an influential coaching staff, and the team atmosphere where peers share common goals.

The seven 45-minute classroom sessions and seven physical training periods involve role-playing, student-created campaigns, and educational games. Instructional aids include pocket-sized food and exercise guides and easy-to-follow student workbooks. Parents are involved with parent-student homework and with the booklet "Family Guide to Sports Nutrition."

The program features learning about anabolic steroids and other drugs, skills to resist drug offers, team ethics and drugfree commitment, drug use norms, vulnerability to drug effects, debunking media images that promote substance abuse, parent, coach, and team intolerance of drug use, and goal-setting for sports nutrition and exercise. Weight-lifting instruction at the school promotes safe training practices, reduces the influence of commercial gyms (where anabolic steroids and other drugs are more available), and highlights curriculum components.

Risk Factors Addressed

Favorable attitudes toward drug use Friends who use Community norms favorable toward drug use Parental attitudes favorable toward drug use

Protective Factors Addressed

Healthy beliefs and clear standards

CSAP Strategy

Information dissemination Education

Type of Strategy

Universal

Populations Appropriate for This Best Practice

Male high school athletes

Evaluating This Best Practice

This best practice comes with an evaluation tool that can be used when implementing this strategy.

Evaluation Tool Cost:

The evaluation tool is free upon request; the cost of analysis varies according to type of analysis.

The following are suggested areas to assess when implementing this practice:

- · Assess understanding of harmful effects of anabolic steroids and other drugs
- Assess belief in personal vulnerability to the adverse effects of anabolic steroids
- · Assess belief that their parents and coaches are intolerant of drug use
- Assess refusal skills
- · Assess belief in steroid-promoting images

Research Conclusions

(Excerpt from Preventing Drug Use Among Children and Adolescents: A Research-Based Guide, National Institute on Drug Abuse, 1997, page 24.)

Student athletes receiving the ATLAS program report: better understanding of the effects of anabolic steroids and other drugs, greater belief in personal vulnerability to the adverse effects of anabolic steroids, and more certainty that their parents and coaches are intolerant of drug use. In addition: improved drug refusal skills, less belief in steroid-promoting media images, more confidence in personal ability to build muscle and strength without steroids, greater self-esteem, and less desire to use anabolic steroids were found among members of the intervention group.

Importantly, these high school athletes continued to resist the temptation to use anabolic steroids and maintained better nutrition and exercise behaviors one year after the intervention. The program contains four booster sessions for each subsequent year of high school.

A more recently published study* also showed positive results including: Significant reductions in new use of alcohol and illicit drugs (marijuana, amphetamines, narcotics); 50% reduction in new use of anabolic steroids; significant reductions in use of "athletic" supplements; 24% reduction in drinking and driving occurrences; improved nutrition behaviors; improved exercise self-efficacy; greater belief in the personal vulnerability to the adverse effects of anabolic steroids; greater belief in one's personal athletic competence.

^{*}Goldberg L., MacKinnon D.P., Elliot D.L., Moe E.L., Carke G., Cheong J.W. The adolescents training and learning to avoid steroids program: Preventing drug use and promoting health behaviors. Arch Pediatr Adolesc Med. Vol 154: 332-338, 2000.

Costs as of December 2001 (Subject to Change)

Training is optional for this program.

Training Time: Six to eight hours

Training Costs: \$1,750 plus expenses for two persons.

Note: Training is for teachers and coaches only. One large room is needed to train teachers and coaches. Two rooms are necessary if coaches and peer leaders are trained.

Strategy Implementation Cost:

\$149.95 (Program Cost, includes 10 Athletes' Packs)

\$39.95 (3-booklet Athletes' Pack for 10 packs) Possible additional photocopying costs for peer leaders.

This translates into a cost of \$510 for 100 participants, plus photocopying costs of about \$1 - \$2 per peer leader.

Special Considerations

Please consider the following before selecting this strategy for your community:

- See training accommodation requirements above
- The best setting is the team environment

Contact Information

For materials, contact:

Sunburst Communications, Inc. Phone: 800.431.1934 or

800.338.3457

For training, technical assistance, or more information on this best practice, contact:

Linn Goldberg, M.D.

Division of Health Promotion and Sports Medicine, CR110

Oregon Health Sciences University 3181 SW Sam Jackson Park Road Portland, OR 97201-3098

E-mail: goldberl@ohsu.edu

Phone: 503.494.6559 Fax: 503.494.1310

BEST PRACTICE: Baltimore Mastery Learning (ML) and Good Behavior Game (GBG) Interventions

Description of Best Practice

(Excerpt reprinted with permission from the Center for the Study and Prevention of Violence, Institute of Behavioral Science, Regents of the University of Colorado, http:// www.Colorado.edu/cspv/blueprints/promise/preventTreat.htm)

The Baltimore Mastery Learning (ML) and Good Behavior Game (GBG) Interventions seek to improve children's psychological well-being and social task performance. The former focuses on strengthening reading achievement to reduce the risk of depression later in life, while the latter aims to decrease early aggressive and shy behaviors to prevent later criminality. Both are implemented when children are in early elementary grades in order to provide students with the skills they need to respond to later, possibly negative, life experiences and societal influences.

The Good Behavior Game is primarily a behavior modification program that involves students and teachers. It improves teachers' abilities to define tasks, set rules, and discipline students, and allows students to work in teams in which each individual is responsible to the rest of the group.

Before the time begins, teachers clearly specify those disruptive behaviors (e.g. verbal and physical disruptions, noncompliance, etc.) which, if displayed, will result in a team's receiving a checkmark on the board. By the end of the game, teams that have not exceeded the maximum number of marks are rewarded, while teams that exceed this standard receive no rewards. Eventually, the teacher begins the game with no warning and at different periods during the day so that students are always monitoring their behavior and conforming to expectations.

The Mastery Learning intervention improves reading skills in order to combat learning problems and subsequent risk for depression. Like the Good Behavior Game, it utilizes a group-based approach in which students are assigned reading units but cannot advance until a majority of the class has mastered the previous set of learning objects.

Risk Factors Addressed

Academic failure Early antisocial behavior

Protective Factors Addressed

Healthy beliefs and clear standards

CSAP Strategy

Education

Type of Strategy

Universal or Selective

Populations Appropriate For This Practice

- Early elementary school children
- Children demonstrating early high-risk behavior

Evaluating This Practice

The following are suggestions of areas you may want to assess if you implement this practice:

- Assess aggressive behaviors
- Assess school achievement, including reading achievement

Research Conclusions

(Excerpt reprinted with permission from the Center for the Study and Prevention of Violence, Institute of Behavioral Science, Regents of the University of Colorado, web site: http://www.Colorado.edu/cspv/blueprints/promise/ preventTreat.htm)

Evaluations of both programs have demonstrated beneficial effects for children at the end of first grade, while an evaluation of the Good Behavior Game has shown positive outcomes at grade six for males displaying early aggressive

At the end of first grade, GBG students, compared to a control group, had:

- Less aggressive and shy behaviors according to teachers,
- Better peer nominations of aggressive behavior.

At the end of first grade, ML students, compared to a control group, showed:

Increases in reading achievement.

At the end of sixth grade, GBG students, compared to a control group, demonstrated:

 Decreases in levels of aggression for males who were rated highest for aggression in the first grade.

For evaluation results see:

Kellam, S.G., Rebok, G.W., Ialongo, N., & Mayer, L.S. (1994). The course and malleability of aggressive behavior from early first grade into middle school: Results of a developmental epidemiologically-based preventive trial. Journal of Child Psychology and Psychiatry, 35 (2) 259-282. VP-2501.

Contact Information

For more information, contact web site: Jeanne Poduska, Deputy Director AIR Center for Integrating Education and Prevention Research in Schools 1000 Thomas Jefferson Street Washington, DC 20007

Phone: 202.944.5417 Dr. Sheppard G. Kellam E-mail: kellam@air.org Phone: 202.944.5418

Web site: http://www.bpp.jhsph.jhu.edu

BEST PRACTICE: Blood Alcohol Concentration Laws

Description of Best Practice

(Excerpt from *Alcohol Alert*, National Institute on Alcohol Abuse and Alcoholism, October 1996, No. 34, p. 1, PH 370.)

States which have lowered the blood alcohol concentration (BAC) limit from 0.10 to 0.08 have seen a reduction in alcohol-related fatal motor vehicle crashes.

Risk Factors Addressed

Community laws and norms favorable toward drug use

Protective Factors Addressed

Healthy beliefs and clear standards

CSAP Strategy

Environmental

Type of Strategy

Universal

Populations Appropriate for This Best Practice

Not specific

Evaluating This Best Practice

The following suggestion is an area you may want to assess if you implement this best practice:

 Assess decline in proportion of fatal crashes involving fatally injured drivers whose BAC's were 0.08 or higher.

Research Conclusions

(Excerpt from *Alcohol Alert*, National Institute on Alcohol Abuse and Alcoholism, October 1996, No. 34, p. 1, PH 370.)

- One study found that states with the reduced limit experienced a 16 percent decline in the proportion of fatal crashes involving fatally injured drivers whose BAC's were 0.08 percent or higher, compared with nearby states that did not reduce their BAC limit.
- In a separate analysis, this study found that states that lowered their BAC limit also experienced an 18 percent decline in the proportion of fatal crashes involving fatally injured drivers whose BAC's were 0.15 or higher, relative to comparison states.

Contact Information

You can also find the document *Save Lives: Recommendation to Reduce Underage Access to Alcohol* on Join Together's web site, *www.jointogether.org*, in the resources section/publications.

For information on how to enact a policy change regarding BAC laws, obtain a free hard copy of *How to Change Local Policies to Prevent Substance Abuse* from:

Join Together 441 Stuart Street, 7th Floor Boston, MA 02116

Phone: 617.437.1500 Fax: 617.437.9394

BEST PRACTICE: Brief Strategic Family Therapy

Description of Best Practice

(Excerpt from Strengthening America's Families' web site, http://www.strengtheningfamilies.org/index.html)

Brief Strategic Family Therapy (BSFT) is a family-based intervention aimed at preventing and treating child and adolescent (ages 8-17) behavior problems including mild substance abuse. BSFT was developed at the Center for Family Studies, a division of the University of Miami Medical School's Department of Psychiatry and Behavioral Sciences, in 1975, and has since been tested and refined in clinical studies.

BSFT is based on the fundamental assumption that adaptive family interactions can play a pivotal role in protecting children from negative influences, and that maladaptive family interactions can contribute to the evolution of behavior problems and consequently is a primary target for intervention. The goal of BSFT is to improve the youth's behavior problems by improving family interactions that are presumed to be directly related to the child's symptoms, thus reducing risk factors and strengthening protective factors for adolescent drug abuse and other conduct problems.

Therapy is tailored to target the particular problem interactions and behaviors in each client family. Therapists seek to change maladaptive family interaction patterns by coaching family interactions as they occur in session to create the opportunity for new, more functional interactions to emerge. Major techniques used are joining (engaging and entering the family system), diagnosing (identifying maladaptive interactions and family strengths), and restructuring (transforming maladaptive interactions). BSFT has been tailored to work with inner city, minority families, particularly African American and Hispanic families, and therapists are trained to assess and facilitate healthy family interactions based on cultural norms of the family being helped.

BSFT is a short-term, problem-focused intervention. A typical session lasts 60 to 90 minutes. The average length of treatment is approximately 12-15 sessions over three months. For more severe cases, such as substance abusing adolescents, the average number of sessions and length of treatment may be doubled. Treatment can take place in the office or home/community settings.

Note: Some funding agencies may classify this as an "intervention" or "treatment" program and consequently, may not fund it with prevention dollars.

Risk Factors Addressed

Family management problems Family conflict

Protective Factors Addressed

Bonding – Family CSAP Strategy Education

Type of Strategy

Indicated

Populations Appropriate for This Best Practice

- Inner city, minority families, particularly African American and Hispanic families
- 8- to 17-year-old youth who are displaying or are at risk for developing behavior problems, including substance abuse

Evaluating This Best Practice

This best practice can come with an evaluation tool that can be used when implementing this strategy. Tools can be tailored to the needs of each program.

Evaluation Tool Cost

The cost of the evaluation tool varies. Please contact Carleen Robinson (see below) for more information.

The following are suggestions of areas you may want to assess if you implement this best practice:

- · Assess change in family management skills
- · Assess rate of behavior problems of youth participants
- Assess rate of alcohol, tobacco, and other drug use by youth participants
- Assess the level of conflict between family members

Research Conclusions

(Excerpt from Strengthening America's Families' web site, http://www.strengtheningfamilies.org/index.html)

BSFT has been rigorously evaluated in a number of studies with experimental designs. The approaches have been found to be effective in improving youth behavior, reducing recidivism among youthful offenders, and in improving family relationships.

Costs as of January 2002 (Subject to Change)

Training Time and Cost:

The Center for Family Studies can customize a training package to meet the needs of a particular agency depending on agency size, level of clinical staff experience, and treatment population. Standard training packages include the following:

- Package I Overview of the model consists of one 3-day beginners' level workshop for up to 30 attendees. Fee: \$6.000
- Package II Intensive intermediate level for up to 30 attendees consists of two 3-day workshops including clinical case consultation. Fee: \$12,000
- Package III Intensive intermediate level for up to 15 attendees consists of three 3-day workshops including clinical case consultation. Fee: \$16,000

Package IV – Certification in BSFT for up to five candidates per agency that consists of: Biweekly review of 5 videotapes of BSFT family therapy, biweekly 2-hour group telephone consultation/feedback, and one 2-day advanced workshop. Fee: \$17,650 (Requisite: Successful completion of Package III – Intensive Intermediate.)

Note: Packages III and IV constitute certification.

Implementation Cost:

Staff requirements for implementing BSFT include: BSFT therapists and a clinical supervisor. In mild to moderate cases we have found that a reasonable clinical load for a full-time therapist is 20 active cases.

BSFT therapists typically have master's level training in mental health, social work or counseling, and at least three years of supervised clinical experience. In addition to skills specific to BSFT, therapist must possess the clinical skills of empathy, timing, ability to provide support and validation, ability to establish working alliances with individuals and families, enthusiasm, and optimism. Cultural competence to work with minority populations is also crucial.

Other program implementation costs include office space, transportation costs (for therapists doing home/community visits or for families to attend therapy in the office). It is rec-

ommended that therapy sessions be either video or audio taped for clinical supervision.

Special Considerations

The following should be taken into consideration before selecting this strategy to be implemented in your community:

 Need to have staff who can learn the model well and who follow through, in order to ensure the effectiveness of the program.

Contact Information

For more information on this program, visit web site: http://www.ncjrs.org/html/ojjdp/jjbul2000_04_3/contents.html

For technical assistance, training and materials:

Carleen Robinson Batista University of Miami Center for Family Studies 1425 NW 10th Avenue, 3rd Floor Miami, FL 33136

E-mail: crobins2@med.miami.edu

Phone: 305.243.4592 Fax: 305.243.5577

Web site: http://www.cfs.med.miami.edu

BEST PRACTICE: Bry's Behavioral Monitoring and **Reinforcement Program**

Description of Best Practice

(Excerpt taken from information provided by Brenna H. Bry, Graduate School of Applied and Professional Psychology, Rutgers University, Piscataway, NJ: "Program Fact Sheet.")

Bry's Behavioral Monitoring and Reinforcement Program is a school-based, early intervention program borne from earlier work on behavior modification and teaching thinking skills.

The program targets seventh and eighth graders and includes the following components:

Collecting Up-To-Date Information about Each Student's Actions Experimenters enter the school each week, record the daily attendance and discipline referrals of program participants, and complete individual "Weekly Report Cards" for each student based on information gained in teacher interviews. During these interviews, teachers are asked whether students had done the following things during the previous week:

- (a) came to class on time
- (b) brought materials needed for classwork
- (c) done the classwork
- (d) exhibited satisfactory behavior, and
- (e) done homework, if it was assigned

Providing Systematic Feedback

Experimenters meet weekly with students in small groups (five to seven students). The "Weekly Report Cards" are distributed and discussed individually. Positive teacher ratings are praised and negative ratings lead to discussions of what the student can do to improve that teacher's impression of his or her behavior. Parents are often contacted throughout the program, by letter, telephone, and home visits to inform them about their child's progress.

Attaching Value to the Student's Actions

Students receive a point for every day that they come to school, arrive on time, and receive no disciplinary action, and for each positive rating they receive on their "Weekly Report Cards." At the end of meetings, students are also given points for obeying specific meeting rules, such as not laughing at or criticizing other people, not touching other people or their possessions, and not talking while others are talking. Students accumulate their points during the year to earn an extra school trip of their own choosing.

Following the two-year intervention, students are invited to biweekly booster sessions, which follow the same format as the original intervention.

Risk Factors Addressed

Academic failure Antisocial behavior

Protective Factors Addressed

None specifically identified

CSAP Strategy

Education

Type of Strategy

Selective

Populations Appropriate for This Best Practice

Seventh and eighth grade students

Evaluating This Best Practice

This best practice does not come with an evaluation tool that can be used when implementing this strategy. Student report cards with grades and attendance can be used as the outcome measurements.

The following are suggested areas to assess when implementing this practice:

- Assess participants' grades and attendance
- Assess number of problem behaviors of participants at
- Assess level of criminal behavior and substance abuse by participants

Research Conclusions

(Excerpt taken from information provided by Brenna H. Bry, Graduate School of Applied and Professional Psychology, Rutgers University, Piscataway, NJ: "Program Fact Sheet.")

Forty 7th graders were selected from a class of 555 students in a large, urban, racially mixed junior high school. Selected students met at least two of the three following criteria: (1) low academic motivation, (2) family problems, and (3) frequent or serious discipline referrals. Students were randomly assigned to either a treatment or control group. Students' tardiness, class preparedness, class performance, classroom behavior, school attendance, and disciplinary referrals were monitored weekly for two years.

For the one-year follow-up study, 30 students from an urban school system plus 36 students from a suburban school system were evaluated. Information was collected from school records and through structured, self-reported interviews with study participants. The interview included questions about employment, alcohol use, drug use, and criminal behavior. Fewer than 50 percent of the intervention subjects attended the booster sessions offered during this 12month period.

Sixty students from the one-year follow-up study participated in the five-year follow-up study. Arrest records were used to assess participant involvement with the criminal justice system. Compared to the control group, experimental students had significantly better grades and attendance at the end of the program. However, these positive effects did not appear until the students had been in the program for two years.

In the year after the intervention ended, experimental students displayed significantly fewer problem behaviors at school than did controls. Eighteen months following the intervention, experimental students reported significantly less substance abuse and criminal behavior. Five years after the program ended, experimental youth were 66 percent less likely to have a juvenile record than were controls.

Costs as of December 2001 (Subject to Change)

Training and technical assistance is not required.

Training Time:

One eight-hour day workshop for 30 participants.

On-going training during the year for 30 participants. The training occurs as 20-minute individual consultations, once every six weeks, by mail, telephone or e-mail.

Training Costs:

\$1,600 plus travel expenses

\$10,500 for on-going training during the year for 30 participants (\$175/hour)

\$1,800 for materials for 30 participants

The Early Secondary Intervention Program (ESIP) manual is available at no cost.

Special Considerations

Please consider the following before selecting this strategy for your community:

- Implementers should like students who are at higher risk.
- Implementers need to have two hours a week during the school day to implement the program. They can either be school employees or come into the school from the community for two hours/week.

Contact Information

The Early Secondary Intervention Program (ESIP) manual is available at no cost from Dr. Brenna Bry.

For training, technical assistance, and materials contact:

Brenna Hafer Bry, Ph.D.

Graduate School of Applied and Professional Psychology

Rutgers University

152 Frelinghuysen Road

Piscataway, NJ 08854-8085

E-mail: bbry@rci.rutgers.edu

Phone: 732.445.2189 Fax: 732.445.4888

BEST PRACTICE: CASASTART 23

BEST PRACTICE: CASASTART

Description of Best Practice

(Excerpt from "Impact of the Children at Risk Program -Comprehensive Final Report II;" and CASASTART (Striving Together to Achieve Rewarding Tomorrows) - A Program of The National Center on Addiction and Substance Abuse at Columbia University. Both are available from The National Center on Addiction and Substance Abuse at Columbia University, New York, NY.)

CASASTART is the second generation of the Children at Risk (CAR) program, a research/demonstration model program that was tested in six cities throughout the United States (Austin, TX; Bridgeport, CT; Memphis, TN; Savannah, GA; Seattle, WA; and Newark, NJ). The CAR program was a partnership between the National Center on Addiction and Substance Abuse at Columbia University (CASA) and the Department of Justice (DOJ) and was funded by agencies under DOJ as well as several foundations and charitable trusts. Based on the findings from the CAR program, CASA received a grant from the Ford Foundation to replicate the CAR model in other neighborhoods. The resulting program is called CASASTART.

CAR was a comprehensive, research-based intervention designed to reach vulnerable children by focusing on small, well-defined neighborhoods characterized by extreme poverty, high crime, and intense social distress. It sought to reduce the overall exposure of youth to crime and drug activ-

CAR focused on 11- to 13-year-old youth attending the middle school served by each of the target neighborhoods. (CASASTART focuses on 8- to 13-year-old children and youths living in impoverished urban neighborhoods.) Eligible youths are identified by program staff – in conjunction with school, police, and court authorities - on the basis of school, family, or personal risk:

- School risk was indicated by such factors as grade retention, special education, poor academic performance, truancy, tardiness, out-of-school suspension, or disruptive behavior.
- Family risk involved family violence or disintegration, family members using drugs or being convicted of crimes, or gang involvement.
- · Personal risk was determined by a youth's known or suspected drug activity, being under juvenile court supervision, delinquency or mental illness, membership in a gang or other delinquent peer group, being a victim of abuse or neglect, or being pregnant or already a parent.

CAR and CASASTART programs were developed around a central core of eight required service components:

• Intensive Case Management — Case management was selected as the optimal approach for combining, coordinating, and simplifying access to community resources. Case managers work with only 15 families to ensure that the children's and families' needs are met through a di-

rect intervention or referral to a more appropriate service provider. During the period of program participation, which can be as long as two years, intensive efforts with the clients take place for 3-4 months and are followed by ongoing monitoring, support and crisis intervention.

- Family Services Family services include, as needed and appropriate, counseling, parenting skills training, stress management/coping skills, and identification and treatment of substance abuse and other health or mental health problems. Referrals are made to education and training programs, job search skills and employment services, and income and social support resources.
- Community-Enhanced Policing/Enhanced Enforcement — All CASASTART and CAR programs include direct participation of police officers as part of the case team. They work one-on-one with children and families and collaborate with case managers on strategies to help individual children and families. They can also perform many other important tasks including being posted on "safe corridors" that children frequent, establishing neighborhood substations, and stepped up supervision and sanctioning of drug offenders to reduce their influence in the neighborhood.
- Criminal/Juvenile Justice Intervention Case managers work with juvenile court personnel to provide community service opportunities and enhanced supervision of children involved in the juvenile justice system.
- After-School and Summer Activities All youth are offered recreational programs, life skills/youth development programs, and training or educational opportunities to ensure that their leisure time is spent in positive and productive ways.
- Education Services Tutoring or homework assistance is available in the program, and remedial or other specialized courses aimed at reducing the chance of academic failure are provided.
- Mentoring Each program makes arrangements with other local organizations to provide mentors for children in need of caring relationships with adults.
- Incentives Incentives such as refreshments, gifts, food or product vouchers, and special events are used to build morale and attachment to the pro-social goals of the program. Stipends may also be provided for goal achievement or community service.

Both CAR and CASASTART service packages vary from one site to another. This variation was and is a deliberate effort to increase the sensitivity of the program to the needs of the community and to institutionalize local "ownership" of the program.

Local program planning focuses on developing staff, program content, and special events that are culturally compatible with the neighborhood, built on existing resources, and address needs identified as high priority by local areas. At the same time, program planners require inclusion of the eight component services in each local program to avoid piecemeal solutions and gaps that could undermine the multifaceted risk reduction strategy.

Risk Factors Addressed

Availability of drugs Persistent antisocial behavior Academic failure beginning in elementary school Friends who engage in the problem behavior

Protective Factors Addressed

Bonding: Peers

Healthy beliefs and clear standards

CSAP Strategy

Alternatives Problem identification and referral Community-based processes Environmental

Type of Strategy

Selective Indicated

Populations Appropriate for This Best Practice

Youth (ages 8-13) at high risk in urban neighborhoods African American Hispanic/Latino

Evaluating This Best Practice

The evaluation tool for this best practice, to be used when implementing this strategy, is not currently being marketed.

The following are suggestions of areas you may want to assess if you implement this promising practice:

- Assess the level of alcohol, tobacco, and other drug use by participants
- Assess participants' attitudes toward ATOD use
- Assess whether participants graduate to the next grade level in school
- Assess positive and negative peer pressure that participants experience

Research Conclusions

(Excerpt from Impact of the Children At-Risk Program – Comprehensive Final Report II.)

The Children at Risk evaluation used an experimental design in which children were randomly assigned to either a treatment group (who received the benefit of a safer neighborhood and the intensive services) or a control group (in which they received only the benefit of a safer neighborhood). The CAR evaluation demonstrated that among youth receiving intervention services:

- CAR reduced drug sales and use, reduced the frequency of violence
- Increased the chances of graduating to the next class in school
- · Increased positive peer group influences, and
- Decreased peer pressure and peer instigation
- CAR youth were less likely to have sold drugs in the past month or year, or to have used gateway drugs or stron-

- ger drugs in the past month, or to have used stronger drugs in the last year, than were youth in the control group
- They were less likely to have friends who were delinquent or who urged them to be antisocial
- They were less likely to feel peer pressure
- They were more likely to feel positive peer support than were youth in the control group

Costs as of December 2001 (Subject to Change)

Training Time:

Once the mental health curriculum is developed, the full training will be six days over a two- to three-month period.

CASASTART training provided by CASA covers the following topics:

- Case management
- Collaboration
- Service integration
- · Working successfully with families
- Youth development theory
- · Youth mental health assessment

Training is only delivered to community partnerships that are implementing CASASTART.

Training Costs:

Approximately \$125,000 per site for a year of training and technical assistance. A unit cost has not been developed as the training is part of the general technical assistance package.

Note: CASA offers a full menu of CASASTART training and technical support services designed to help new sites during their first year of program implementation. Interested agencies and communities should call the contact listed below to discuss how CASA's technical assistance service could be tailored to their communities' needs and resources.

Special Considerations

Please consider the following before selecting this strategy for your community:

- CASASTART is a new way of doing business to help atrisk youth and their families. The CASASTART partnership of community agencies, police departments and schools is complex and difficult to manage because of the different cultures, languages, goals, etc. manifest in each agency.
- Much of the work of managing CASASTART relates to the work of managing the partnership. Agencies that seek to undertake the CASASTART work should have histories of collaboration, be very well regarded by their community and be willing to change the way they do business on behalf of young people and families.

Contact Information

For training, technical assistance, and materials contact:

Lawrence F. Murray, CASA Fellow

The National Center on Addiction and Substance Abuse at Columbia University

633 Third Avenue

New York, NY 10017

E-mail: lmurray@casacolumbia.org

Phone: 212.841.5208 Fax: 212.956.8020

BEST PRACTICE: CEDEN Family Resource Center

Description of Best Practice

(Excerpt from Strengthening America's Families' web site http://www.strengtheningfamilies.org/index.html)

CEDEN (Center for Development, Education and Nutrition) provides comprehensive services to promote and strengthen families in need of prenatal, early childhood, and parenting education. The agency's programs seek to improve birth outcomes of pregnant adolescents and at-risk women by providing information to reduce the incidence of premature and low birthweight babies. The agency also provides services to prevent and reverse developmental delays, increase positive parenting behaviors, reduce injuries, and ensure timely immunizations. CEDEN serves primarily low socioeconomic status families and parents with children 0-to-5 years-old who have developmental delays or are at risk of becoming developmentally delayed.

CEDEN's services include an early childhood intervention program for children who are severely delayed, or have a medical condition likely to result in developmental delays. CEDEN's home-based programs accommodate family needs by working with children at child care centers, relatives' homes, shelters for homeless or battered women, and other community shelters. Frequency of home visits is based on family needs, ranging from weekly to monthly visits. Parent educators deliver a series of educational materials including: early childhood stimulation activities, age-appropriate activities, basic health and nutrition care, and home safety, and a Pro-Family Curriculum focusing on child development, behavior, and skill building.

Please note: CEDEN Family Resource Center recently merged with Any Baby Can. The new agency name is Any Baby Can Child and Family Resource Center.

Risk Factors Addressed

Family management problems

Protective Factors Addressed

Bonding - families Skill building

CSAP Strategy

Education

Type of Strategy

Selective

Populations Appropriate for This Best Practice

• Children ages 0-5 with developmental delays or at risk of becoming developmentally delayed

- · Pregnant adolescents and women at risk and their chil-
- · Low income families

Evaluating This Best Practice

The following are suggested areas to assess when implementing this practice:

- Assess increase in family management skills
- Assess improvements in developmental status of children
- Assess increase in family cohesion

Research Conclusions

(Excerpt from Strengthening America's Families' web site, http://www.strengtheningfamilies.org/index.html)

Program evaluations demonstrate CEDEN's effectiveness in improving the developmental status of young children with delays. Children participating in the program maintain upto-date immunizations at a level higher than average for the community. Parents report great satisfaction in learning and using alternative disciplinary methods. They also feel they understand their children better after participating in CEDEN's programs. Parenting classes and support groups help reduce the social isolation of Spanish speaking mothers by facilitating friendships and boosting self-esteem.

Costs and Special Considerations

Please inquire of the contact listed below.

Contact Information

Please Note: CEDEN Family Resource Center recently merged with Any Baby Can. The new agency name is Any Baby Can Child and Family Resource Center.

Web site: http://www.abcaus.org

(The web site contains information on the services to families that they offer. No information on training and technical assistance to replicate their program is currently available on their web site.)

For training, technical assistance, and materials contact:

Terry Arguello and Janet Chapman

Any Baby Can Child and Family Resource Center

1208 East 7th Street Austin, TX 78702-3223

E-mail: terrya@abcaus.org

janetc@abcaus.org

Phone: 512.477.1130

BEST PRACTICE: Changing the Conditions of Availability

Description of Best Practice

(Excerpts taken from *Preventing Problems Related to Alcohol Availability: Environmental Approaches: Practitioners' Guide,* Center for Substance Abuse Prevention, pp. 13-16.)

Alcohol availability is associated with social, civic, and health problems and can be modified through government and community actions. These actions include two distinct dimensions: Controlling outlet density and restricting days and hours of alcohol sales, and restricting availability of alcohol at sporting and recreational events, as well as at special locations such as parks and other publicly owned facilities. While both aspects of this prevention approach are important, substantially more research is needed on the second (i.e., restricting availability at special events and locations).

Lessons Learned

Alcohol consumption levels and the rates of alcohol-related problems tend to increase when a greater density of outlets and increased hours of sale increase the availability of alcohol. Although there is a clear relationship among alcohol outlets, high poverty rates and violence, the location and density of outlets are themselves related to community power. For example, zoning laws often keep liquor stores and high-risk businesses out of affluent neighborhoods.

The following lessons pertain to the regulation of alcohol availability at special events and locations: A wide range of restrictions can be placed on special events, including restrictions on operating hours, noise levels, general location of event, location of alcohol sales or places of consumption (such as beer gardens) advertising of alcohol, alcohol sponsors, age of servers, quantity of sales, size of containers, and condition of the customers. Alcohol sales can be discontinued before an event is over, giving patrons some time between their last drink and driving home. For example, alcohol sales can be discontinued at the end of the third quarter of a football game. Sales of food and nonalcoholic beverages can be required during and after alcohol sales are cut off.

Recommendations for Practice

The following recommendations of the Expert Panel address general issues such as geographic spacing of outlets and community compatibility: Collect data on outlet density, become aware of licensing laws and processes, and consider neighborhood compatibility.

The following Expert Panel recommendations regarding regulations at special events and locations address general issues such as alcohol control activities at community events: Plan ahead, train servers, disseminate rules, use physical visual aids to separate drinking adults from nondrinking ones, educate promoters, and address the need for a balance of interests.

Risk Factors Addressed

Availability of drugs

Protective Factors Addressed

Healthy beliefs and clear standards

CSAP Strategy

Environmental

Type of Strategy

Universal

Populations Appropriate for This Best Practice

None specifically identified

Evaluating This Best Practice

The following are suggested areas to assess when implementing this practice:

- Assess the number of alcohol outlets per capita
- Assess the rates of alcohol consumption and alcohol-related problems
- Assess the number of intoxicated persons and the rate of abusive incidents involving intoxication at sporting arenas and special events

Research Conclusions

(Excerpts taken from *Preventing Problems Related to Alcohol Availability: Environmental Approaches: Practitioners' Guide,* Center for Substance Abuse Prevention, p. 14.)

The research evidence reviewed indicates that it is possible to implement efforts that result in changes in alcohol availability: There is medium evidence that an increase in the number of outlets per capita increases rates of alcohol consumption and alcohol-related problems. The research and practice evidence reviewed indicates that it is possible to pass legislation regulating the sale and consumption of alcohol at special events and locations. There is suggestive but insufficient evidence that controlling alcohol availability and training servers in sporting arenas and at special events reduces the number of intoxicated persons and the rate of abusive incidents involving intoxication.

Costs and Special Considerations

Not available

Contact Information

For more information on how to implement this best practice:

Order a free copy of CSAP's *Preventing Problems Related to Alcohol Availability: Environmental Approaches*, 1999, order no. "PHD 822, 823 and 825" from SAMHSA's National Clearinghouse for Alcohol and Drug Information (NCADI).

Phone: 800.729.6686, or Web site: http://ncadi.samhsa.gov.

BEST PRACTICE: Changing Hours and Days of Sale

Description of Best Practice

(Excerpts taken from Preventing Problems Related to Alcohol Availability: Environmental Approaches: Practitioners' Guide, Center for Substance Abuse Prevention, p. 16.)

Governments often influence the availability of alcohol by specifying the hours of sale at specific sites and by allowing sales only on certain days. Although seldom designed for prevention purposes, such changes are natural experiments that provide opportunities to examine the effects on overall alcohol sales and patterns of consumption.

Lessons Learned

- · Alcohol consumption levels and rates of alcohol-related problems tend to increase when the hours and days of
- Reducing availability is difficult in an era when consumer convenience is such a high priority. Even though one experiment (in Norway) demonstrated clear positive results from Saturday closing, the political support was lacking to continue or extend the closing.

Recommendations for Practice

- Know the law. It's important for communities to be familiar with state and local laws regarding hours and days of operation.
- Be alert for chances to make the case for limited availability. Knowing the law will enable communities to recognize and take advantage of opportunities to exercise control.
- Be alert to seemingly minor or innocuous changes in availability. Proposals to extend hours or days of sale should be evaluated in light of the fact that it is nearly impossible to reverse such changes.

Risk Factors Addressed

Availability of drugs

Protective Factors Addressed

Healthy beliefs and clear standards

CSAP Strategy

Environmental

Type of Strategy

Universal

Populations Appropriate for This Best Practice

None specifically identified

Evaluating This Best Practice

The following suggestion is an area you may want to assess if you implement this best practice:

Assess the increase or decrease of the number of hours or days of alcohol sales compared to the rates of alcohol consumption and alcohol-related problems.

Research Conclusions

(Excerpts taken from Preventing Problems Related to Alcohol Availability: Environmental Approaches: Practitioners' Guide, Center for Substance Abuse Prevention, p. 16.)

The research evidence reviewed indicates that in relation to changes in the days and hours of alcohol sales, there is medium evidence that expanding the hours or days of alcohol sales increases the rates of alcohol consumption and alcohol-related problems.

Costs and Special Considerations

Not available

Contact Information

For more information on how to implement this best practice:

Order a free copy of CSAP's Preventing Problems Related to Alcohol Availability: Environmental Approaches, 1999, order no. "PHD 822, 823 and 825" from SAMHSA's National Clearinghouse for Alcohol and Drug Information (NCADI).

Phone: 800.729.6686, or Web site: http://ncadi.samhsa.gov

BEST PRACTICE: The Child Development Project

(CSAP Demonstration Grant #2647)

Description of Best Practice

(Excerpt from "Understanding Substance Abuse Prevention – Toward the 21st Century: A Primer on Effective Programs," Center for Substance Abuse Prevention, unpublished document.)

The Child Development Project was a five-year initiative designed as a comprehensive school-based program to reduce risk and bolster protective factors related to substance use. The program was implemented at 12 demonstration schools in six school districts located throughout the United States (six on the West Coast, two each in the South, the Southeast and the Northeast.) Youth populations targeted at each school also varied widely, ranging from 2% to 95% receiving free or reduced lunch, 26% to 100% being members of minority groups, and having achievement test scores ranging from the 24th to the 67th percentile.

The effort attempted to transform the school into a "Community of Caring", in which a student's intrinsic motivation to learn was nurtured, and supportive social relationships, sense of common purpose, and a commitment to pro-social values responsive to children's developmental needs were commonplace. The specific intervention activities cited to accomplish these objectives included: cooperative classroom learning; implementing "values rich" literature-based reading and language arts programs; establishing a developmental discipline program and classroom management plan with input from the students vis-a-vis appropriate behavioral contingencies; developing classroom and school-community building projects that fostered cooperation and communication between teachers, students and families; and homeside activities in which youth and families work together to develop classroom presentations,

The basic mode of implementation was that of trainers training trainers. Initially a small cadre of supervisory staff and teachers were trained by project and school district staff in the spring of 1992. They returned to their schools and trained staff there. Trained school staff provided most direct services including effecting cooperative classroom learning efforts, modifying curricula, as well as designing and implementing the discipline policies.

Risk Factors Addressed

Low commitment to school

Protective Factors Addressed

Bonding: School

CSAP Strategy

Information dissemination Education Community-based process Environmental

Type of Strategy

Universal

Populations Appropriate for This Best Practice

- Elementary school
- Multi-ethnic
- Multi income levels

Evaluating This Best Practice

This best practice comes, upon request, with an evaluation tool that can be used when implementing this strategy. There is no cost for the tool.

Note: An extensive student questionnaire (grades 3-6) and teacher questionnaire was developed for research use. This is a costly measure to administer and analyze. Data analysis service is not provided.

The following are suggested areas to assess when implementing this practice:

- Assess degree that students like school and their learning motivation
- Assess improvements in teacher practices leading to positive changes in classroom behaviors

Research Conclusions

Excerpt from "Understanding Substance Abuse Prevention — Toward the 21st Century: A Primer on Effective Programs," Center for Substance Abuse Prevention, unpublished document.)

Findings provide considerable support for CDP's underlying conceptual model, as well as evidence that CDP training had a statistically significant, moderate effect on classroom practices which, in turn, increased students' sense of community and had positive effects on a number of student outcome variables.

In summary, researchers found data patterns expected from their theoretical orientation supporting the implementation model's effectiveness. Further, treatment-comparison and internal contrasts, using fidelity of implementation as a means to partition schools demonstrated clearly that when implemented more fully, program effects increased in the areas of skills, behaviors, school achievement and bonding, and substance use.

Costs as of May 2001 (Subject to Change)

Training Time: Three days (18 hrs)

Training Costs:

\$6,000 which can be shared by up to five school teams

Note: This is a training of trainers approach. A team of four to six participants from a school receives a three-day institute training and then provides staff development to a school staff.

BEST PRACTICE: The Child Development Project 29

Strategy Implementation:

- \$450 per school for the collegial study package which includes videos and tools for the follow up training and program implementation in each school
- \$50 per teacher for materials and books

Special Considerations

Please consider the following before selecting this strategy for your community:

- Classroom teachers attend approximately 10 hours of staff development from the school team and participate in 10 hours of collegial study throughout the year.
- · Schools must be prepared to provide on-going staff development support to teachers in program implementation and to purchase classroom materials.

Contact Information

For more information on this program, visit web sites: http://modelprograms.samhsa.gov http://www.devstu.org

For training information contact:

Stefan Dasho

Phone: 510.533.0213 x 270 or

800.666.7270

For professional development services, curriculum, and teacher resource materials information contact:

Denise Wood, Information Coordinator **Developmental Studies Center** 2000 Embarcadero, Suite 305 Oakland, CA 94606-5300

E-mail: info@devstu.org Phone: 510.533.0213 x 239 or

800.666.7270

Fax: 510.464.3670 To order materials, contact:

E-mail: pubs@devstu.org

510.533.0213 x 281 Phone:

BEST PRACTICE: Communities Mobilizing for Change on Alcohol

Description of Best Practice

(Excerpt from *Alcohol Epidemiology Program*, University of Minnesota)

CMCA is a community organizing effort designed to change policies and practices of major community institutions in ways that reduce access to alcohol by teenagers. CMCA was developed and evaluated in a 15-community randomized trial by the Alcohol Epidemiology Program at the University of Minnesota School of Public Health, under the direction of Professor Alexander C. Wagenaar.

The intervention approach involves activating the citizenry of communities to achieve changes in local public policies and changes in the practices of major community institutions, such as law enforcement, licensing departments, community events, civic groups, churches and synagogues, schools, and local mass media. The objective is to reduce the flow of alcohol to youth from illegal sales by retail establishments, and from provision of alcohol to youth by other adults in the community.

(Excerpt from *Journal of Community Psychology*, Vol. 27, No. 3, 315-326 (1999) © 1999 John Wiley & Sons, Inc.)

CMCA used a community organizing approach to implement changes in local institutional policies. Institutional change included both formalized behavior, such as new ordinances and written policies, and informal practices such as more frequent patrolling by local police agencies or increased media coverage of alcohol-related issues. Organized citizens in each of the seven CMCA intervention communities identified and promoted a variety of policy initiatives designed to change the local environment in a way that made it more difficult for young people to obtain alcohol, and made underage drinking less acceptable within the local culture.

Part-time local organizers in each intervention community followed an organizing process that included seven stages:

- Assessing the community assessing community wants, needs and resources.
- Creating a core leadership group identifying key supporters to plan and implement the organizing campaign.
- Developing a plan of action creating a workplan and timeline for implementing activities and accomplishing goals.
- 4) Building a mass base of support attracting new supporters and building community awareness and involvement in the campaign.
- Implementing the action plan implementing activities identified by the campaign leadership that were designed to achieve the goals.
- 6) Maintaining the organization and institutionalizing change — initiating activities to sustain the campaign and its accomplishments.

Evaluating changes — evaluating campaign activities and outcomes.

Risk Factors Addressed

Community laws and norms favorable toward alcohol use Availability of alcohol

Protective Factors Addressed

Healthy beliefs and clear standards

CSAP Strategy

Environmental

Type of Strategy

Universal

Populations Appropriate for This Best Practice

- 18- to 20-year-olds
- · On- and off-sale alcohol retail merchants

Evaluating This Best Practice

The following are suggested areas to assess when implementing this practice:

- Assess 18- to 20-year-olds' alcohol consumption, attitudes and compliance with policies
- Assess merchant compliance in off-sale and on-sale outlets, with alcohol policies and restrictions.

Research Conclusions

(Excerpt from http://modelprograms.samhsa.gov)

CMCA was evaluated in a fully randomized trial across 15 communities. Data collection included pre and post in-school surveys of 12th graders, telephone surveys of 18- to 20-year-olds and alcohol merchants, direct testing of the propensity of alcohol retailers to sell to young buyers, and monitoring changes in relevant practices of community institutions.

Results show that:

- CMCA significantly and favorably affected the behavior of 18- to 20-year-olds and the alcohol sales practices of bars and restaurants
- Alcohol retailers increased age-identification checking and reduced sales to minors, and 18- to 20-year-olds were less likely to try to purchase alcohol, less likely to frequent bars, less likely to drink and, importantly, less likely to provide alcohol to other teens.
- Arrests for driving under the influence of alcohol also declined significantly among 18- to 20-year-olds. Younger adolescents were not significantly affected by CMCA.

Costs and Special Considerations

Not available

Contact Information

For more information on this program, visit web site: http://modelprograms.samhsa.gov

No technical assistance, training, or manuals are available for this strategy. Several papers were written documenting the CMCA project. To obtain citations for and to order all of the papers, visit web site:

www.epi.umn.edu/alcohol

These papers can assist you in replicating the strategy. The following can also be found on their web site: alcohol compliance checks procedures manual, model ordinances, model public policies, model institutional policies, and reprints of papers.

For questions regarding the research papers, contact: Alexander C. Wagenaar, Ph.D. Division of Epidemiology School of Public Health

1300 South 2nd Street, Suite 300 Minneapolis, MN 55454-1015

E-mail: wagenaar@epi.umn.edu

Phone: 612.624.8370 Fax: 612.624.0315

BEST PRACTICE: Communities That Care

Description of Best Practice

(Excerpt from materials provided by Channing Bete in December 2001.)

The Communities That Care (CTC) process is an operating system that provides research-based tools to help communities mobilize to promote the positive development of children and youth and to prevent adolescent problem behaviors that impede positive development including substance abuse, delinquency, teen pregnancy, school dropout, and violence.

The CTC process was developed by David Hawkins, Ph.D., and Richard Catalano, Ph.D., to help communities plan, implement, and evaluate proven-effective prevention programs to meet their particular needs. These programs can address some or all focus areas – family, school, community-based youth, and community. The full CTC process is based on the public health model and includes five phases. (Alternative CTC programs can be customized to fit specific community needs.)

Phase I: Getting Started — Create preliminary organization and identify community readiness issues.

Phase II: Getting Organized — Engage key leaders, educate and involve the community, and address readiness issues.

Phase III: Developing a Community Profile — Collect data; analyze and prioritize community risk and protective factors. Conduct a resource assessment.

Phase IV: Creating a Comprehensive Youth Development Plan — Identify strategies to address community priorities, matching proven-effective programs to specific community needs.

Phase V: Implementing and Evaluating Programs — Implement programs, conduct evaluations and refine strategies.

The Communities That Care operating system helps communities to:

- Mobilize and engage diverse members of the community in positive youth development.
- Target scarce resources to most effective use for positive youth results.
- Implement a clear decision-making process for allocating funding and other resources.
- Establish a shared vision, common language and collaborative prevention planning structure.
- Develop a data-driven profile of community strengths and challenges.
- Establish action priorities based on the data showing community needs.
- Develop clear and measurable outcomes that can be tracked over time to show progress.

Risk Factors Addressed

Low neighborhood attachment and community disorganization

Community laws and norms favorable toward drug use, firearms and crime

Transitions and mobility

Protective Factors Addressed

Healthy beliefs and clear standards Bonding: Opportunities, skills and recognition

CSAP Strategy

Community-based process

Type of Strategy

Universal

Populations Appropriate for This Best Practice

Not specified

Evaluating This Best Practice

This best practice comes with an evaluation tool that can be used when implementing this strategy. The evaluation tool is a youth survey that can be done prior to training and implementation of programs and then 1-2 years following.

Evaluation Tool Cost:

\$1.80 per student survey plus \$700 report charge per county and/or \$500 report charge per individual school

The following suggestion is an area you may want to assess if you implement this best practice:

Assess the community coalition's progress in conducting an assessment of risk and protective factors in their community and in implementing strategies to reduce prevalent risk and protective factors.

Research Conclusions

(Excerpt from *Communities That Care Prevention Strategies: A Research Guide to What Works, Developmental Research and Programs,* 1996, pp. 89-90 and materials from Channing Bete Company.)

The following research relates to the effectiveness of the Communities That Care in helping communities to mobilize for prevention needs assessment; and prevention program planning, implementation, and evaluation:

Results from the TOGETHER! project show that multiple communities can be mobilized using the Communities That Care strategy and that, with sufficient training, community prevention boards are both willing and able to conduct assessments of risk and protective factors in their community and implement promising risk reduction strategies.

Of the 40 Oregon communities that initially responded to the invitation to participate in the project, thirty-five completed all three of the Communities That Care trainings. Within a year after training, twenty-eight boards had completed risk-focused prevention plans and less than a year into the planning and implementation phase, 27 had begun implementing risk reduction strategies. Four years later, 31 boards were still active, and 28 of them were implementing risk reduction programs (Harachi et al., 1995).

A comparison of the Communities That Care (CTC) strategy used in the TOGETHER! project and the Washington State Community Youth Activity Program (CYAP) showed that CTC was more effective in mobilizing communities for the design and implementation of risk reduction strategies. Although both projects were successful in mobilizing community boards to plan and implement prevention activities, the Communities That Care process was more successful than the CYAP project at promoting planning and program activities aimed at specific, empirically-based risk factors identified through a community risk assessment process (Arthur et al., 1994).

Costs as of December 2001 (Subject to Change)

Training Costs/Time:

\$3,400 for 80 participants for a one-half day Key Leader Orientation

\$5,500 for 40 participants for two days of Community Board Orientation

\$3,400 for 40 participants for a one-day Community Assessment Training

\$3,400 for 40 participants for a one-day Community **Resources and Strengths Training**

\$8,000 for 40 participants for two days of Community Planning Training

Special Considerations

None specified by program developers

Contact Information

Miriam Cody **Channing Bete Company** One Community Place South Deerfield, MA 01373-0200

E-mail: mcody@channing-bete.com

Phone: 413.665.7611 or

800.828.2827

800.329.2939 Fax:

Web site: http://www.channing-bete.com

BEST PRACTICE: Counter-Advertising (Tobacco Specific)

Description of Best Practice

(Excerpt from: Reducing Tobacco Use Among Youth: Community-Based Approaches: A Guideline for Prevention Practitioners, Center for Substance Abuse Prevention, 1997, Prevention Enhancement Protocols Systems Series 1, pp. 10-12.)

The primary goal of counter-advertising is to change perceived norms among children and adolescents regarding tobacco use. Research and experience demonstrate that adolescents develop attitudes, beliefs, and behaviors regarding tobacco use from peers, family members, television, and other cultural sources. Adolescents often think that tobacco use is more widespread and universally acceptable than it actually is. Advertising links tobacco use with peer acceptance, success, and good times. Media messages that promote negative images about tobacco use, reveal the number of teens who actually use tobacco, and address the unacceptableness of tobacco use should help change these perceived norms.

Activities:

- · Radio and television campaigns
- Multilevel media campaigns that include billboards, posters, magazines, radio, and television
- A mass-media campaign linked to a school-based prevention intervention
- Airing of anti-tobacco media campaigns on prime-time television

Risk Factors Addressed

Community laws and norms favorable toward drug use Favorable attitudes toward drug use

Protective Factors Addressed

Healthy beliefs and clear standards

CSAP Strategy

Environmental

Type of Strategy

Universal

Populations Appropriate for This Best Practice

No specific populations

Evaluating This Best Practice

The following are suggested areas to assess when implementing this practice:

- Assess increase of exposure of children and adolescents to negative messages about using tobacco
- Assess increase of positive messages about not using tobacco

- Assess increase in adolescents' ability to identify hidden messages in tobacco advertising
- Assess increase in adolescents' awareness of tobacco industry marketing tactics

Research Conclusions

(Excerpt from: Reducing Tobacco Use Among Youth: Community-Based Approaches: A Guideline for Prevention Practitioners, Center for Substance Abuse Prevention, 1997, Prevention Enhancement Protocols Systems Series 1, pp. 10-12.)

The research evidence reviewed indicates that it is possible to implement counter-advertising interventions: There is strong evidence that counter-advertising is effective in changing the attitudes of adolescents about tobacco use. There is medium evidence that counter-advertising is effective in reducing adolescent tobacco use.

Lessons Learned From Reviewed Evidence

- Counter-advertising, in the form of multi-component media-based prevention efforts, can have an effect on youth with regard to awareness of media campaigns, decreased smoking prevalence, and nonsmokers' decreased intention to start. These efforts demonstrate the ability to result in increased negative attitudes toward smoking, increased understanding of the consequences of smoking, and decreased rates of friends' approval of smoking.
- Multi-component prevention efforts are more effective than single-component prevention programs. Media campaigns have been shown to support and promote other components and vice versa. Effective media campaigns involve linkages with other intervention activities.
- To be effective, media messages should be age appropriate and designed with the target audience's developmental stage in mind. In particular, messages should not be too subtle or too sophisticated.

Costs and Special Considerations

None identified

Contact Information

For more information on this best practice: order a free copy of the following publications from SAMHSA's National Clearinghouse for Alcohol and Drug Information (NCADI) at:

Phone: 800.729.6686, or Web site: http://ncadi.samhsa.gov

Reducing Tobacco Use Among Youth: Community-Based Approaches, Center for Substance Abuse Prevention, 1997, Prevention Enhancement Protocols Systems Series 1: publication order no. "PHD 744" (for 12-page community guide) "PHD 745" (for prevention practitioner's guide) and "PHD 746" (full document).

BEST PRACTICE: Creating Lasting Connections 35

BEST PRACTICE: Creating Lasting Connections

(CSAP Demonstration Grant #1279)

Description of Best Practice

(Excerpt from "Understanding Substance Abuse Prevention Toward the 21st Century: A Primer on Effective Programs," Center for Substance Abuse Prevention, unpublished.)

Creating Lasting Connections (CLC) was designed to: work with both community and family systems to identify youth and parents/guardians at high-risk for AOD (alcohol/other drug) use, increase familial resilience to and decrease risk for AOD use, provide/refer families in need to appropriate social service agencies, and to mobilize communities to prevent AOD use.

Because churches already foster natural support systems, they were identified as the pivotal community agency from which to implement this culturally competent/appropriate early intervention program for high-risk youth age 11-15 and their families.

Subsequent to being selected, church communities developed Church Advocate Teams (CAT) composed of 5-10 church staff and nominated community members. CAT staff underwent an average of 20 hours of training over seven sessions, after which they were tasked with performing outreach activities, identifying and recruiting high-risk one hundred 15-year-olds and their families, scheduling and performing family training, preparing and implementing field data collection, and preparing linkages for successful selfreferrals with various human service providers.

Initially, parents/guardians and teens met in separate sessions before meeting as intact families in the final sessions. Participating parents/guardians received about 55 hours of training on AOD issues (20 hours) parenting skills (20 hours) and communication skills (15 hours)

Youth received about 15 hours of training concerning AOD issues, communication skills, and refusal skills.

Families requiring AOD intervention or other social services were referred to appropriate agencies by the CAT leader or case manager. CAT members and/or the staff case manager performed telephone and/or in-house follow-ups with participating families for one year subsequent to their participation in CLC.

Note: Although the original research for Creating Lasting Connections was conducted in churches, this program is both community and school-based by design.

Risk Factors Addressed

Family conflict Family management problems Parental attitudes and involvement Early first use

Protective Factors Addressed

Bonding: Family

Skills: Social competence

CSAP Strategy

Information dissemination Education Problem identification and referral Community-based process

Type of Strategy

Selective

Populations Appropriate for This Best Practice

11- to 15-year-old youth and their parents/guardians

Evaluating This Best Practice

This best practice comes with an evaluation tool that can be used when implementing this strategy.

Evaluation Tool Cost:

\$300. This cost covers:

- Self-administered surveys for both youth and parents
- The psychometric properties of the scales in the surveys
- · Survey administration and scoring guidelines
- · Parent consent forms
- · Contact information for technical assistance on evaluating CLFC
- · Permission to copy surveys for evaluating the CLFC Program (only CLFC)

The following are suggested areas to assess when implementing this practice:

- · Determine whether family management skills were enhanced
- Determine improved bonding with mother, father, and
- Determine if more honest communication between family members exists
- · Determine if the onset of AOD use was delayed overall

Research Conclusions

(Excerpt from "Understanding Substance Abuse Prevention - Toward the 21st Century: A Primer on Effective Programs," Center for Substance Abuse Prevention, unpublished.)

Results from this study are complex, deriving from a total of 10 experimental sites assessed over 5 years. Still, data indicate that the intervention was effective in increasing a number of resiliency factors, and that these improvements were related to AOD use.

Overall, these data indicate that as the intervention improved family function and community empowerment, parental and youth substance use decreased.

Costs as of May 2001 (Subject to Change)

Training Time: 40 - 80 hours

Training Costs:

\$750 per participant (for each of one or two weeks of training in Louisville) OR \$200 to \$1,200 per day (depending on the number of trainers and their level of experience) plus travel, lodging and expenses for on-site training.

Note: Training is strongly recommended, although training and technical assistance are not required. Please see further training comment in "Special Considerations."

Strategy Implementation:

Approximately \$17,500 for 40 families (approximately 50 youth and 40 parents) $\,$

Note: This program has three separate adult modules and three separate youth modules. Implementation cost is difficult to predetermine because the program has a variety of implementation choices creating correlating fluctuations in costs. It is foreseeable that costs could range anywhere from minimally \$1,500 to \$250,000 when serving 100 families per year. For agencies serious about program implementation as designed, the typical first-year budget is \$25,000 and up, while costs in subsequent years drop considerably.

Special Considerations

Please consider the following before selecting this strategy for your community:

 Agencies interested in implementing the CLFC curriculum are encouraged to complete a readiness assessment survey designed for COPE's staff to determine the appropriate level of training needed. (Most agencies find one-week of training sufficient.)

- In addition, custom trainings are provided for groups onsite, lasting between three and nine days.
- COPE offers a list of influential and effective trainer characteristics, including: outgoing; caring; non-judgmental; able to recognize, name and express other feelings as they occur; and other characteristics.
- Although the original research for Creating Lasting Connections was conducted in churches, this program is both community and school-based by design.

Contact Information

For more information on this program, visit web sites:

http://modelprograms.samhsa.gov and

http://www.copes.org

For training, technical assistance, materials and additional program information, contact:

Ted N. Strader, M.S.

Council on Prevention Education: Substances, Inc.

845 Barret Avenue Louisville, KY 40204

E-mail: tstrader@sprynet.com

Phone: 502.583.6820 Fax: 502.583.6832

Teresa Boyd can also be contacted at the above numbers for more information about the program.

BEST PRACTICE: DARE to Be You

(CSAP Demonstration Grant #1397)

Description of Best Practice

(Excerpt from materials provided by DARE To Be You staff in December 2001.)

DARE To Be You (DTBY) is a multilevel, primary prevention program for children 2 to 5 years old and their families. It significantly lowers the risk of future substance abuse and other high-risk activities by dramatically improving parent and child resiliency factors in the areas of communication, problem solving, self-esteem, and family skills. Program interventions are designed to:

- · Improve parents' sense of competence and satisfaction with being a parent
- · Provide parents with knowledge and understanding of appropriate child management strategies
- · Improve parents' and children's relationships with their families and peers
- Boost children's developmental levels

The DARE To Be You program should have a site sponsor a key agency that works with families. While the site sponsor may vary with the needs of the community, it must be respected by the community. Sponsors may be Head Start or other preschool educational programs, schools, family centers or coalition groups. The program is delivered to families at a site convenient to the families in a location comfortable for families to attend. The program consists of three components including a:

- · Family Component, which offers parent, youth, and family training and activities for teaching self-responsibility, personal and parenting efficacy, communication and social skills, and problem-solving and decision-making skills. It consists of an initial 12-week family workshop series (30 hours) and semiannual, 12-hour reinforcing family workshops. (After-DARE support groups are also recommended.)
- School Component, which trains and supports teachers and child care providers who work with the target youth.
- Community Component, which trains community members who interact with target families, health department, social services, family center personnel, probation, and counselors.

Both School and Community Component participants have the same 15-hour training requirement. Training for childcare providers and involved community members will also be held at a placed deemed appropriate by the site sponsor.

DARE To Be You program materials are available in English and Spanish.

Risk Factors Addressed

Family management problems

Protective Factors Addressed

Skills: Problem-solving and communication Bonding: Family

CSAP Strategy

Education

Type of Strategy

Universal Selective

Populations Appropriate for This Best Practice

- · Two- to five-year-old children and their parents
- Native American
- Hispanic/Latino
- Caucasian
- · Urban, Rural, Suburban

Evaluating This Best Practice

This best practice does not come with an evaluation tool that can be used when implementing this strategy. The program's instrument was a compilation of instruments "owned" by other authors. An evaluation protocol is provided describing the instruments and costs. Evaluation Protocol Handbook Cost: \$3.00

The following suggestion is an area you may want to assess if you implement this best practice:

· Assess whether family management skills were enhanced, including appropriate control techniques.

Research Conclusions

(Excerpt from materials provided by DARE To Be You staff in December 2001.)

Participants of DARE To Be You showed:

- · Increased parental effectiveness and satisfaction, maintained over two years*
- Increased appropriate parental limit setting, maintained for two years
- Decreased parental child blaming and harsh punishment
- Increased child developmental level, maintained for at least two years*

Outcomes include:

- 95% of the families completed the intervention with at least 20 hours
- 80% of the families completed with more than one adult family member
- 45% of the families had a male father figure participate and complete the intervention

^{*}Compared to control group

- Satisfaction with support systems and self-sufficiency increased significantly
- Families report children better self-managed and better family communication

Costs as of December 2001 (Subject to Change)

Training Time: 20 - 24 hours

Training Cost:

\$4,200 for a 20-hour training plus travel and per diem expenses for trainer. This included a set of seven manuals, one activity book, and postage.

Note: Up to 35 people can be trained. The training is designed with community needs in mind, e.g., implementers only, or implementers and community/agency collaborators. Materials (books and kits) are extra and selected according to community need.

For additional cost information, please contact DARE To Be You.

Special Considerations

Please call the contact below.

Contact Information

For more information on this program, visit web site: http://modelprograms.samhsa.gov

For training, technical assistance, and materials contact:

Jan Miller-Heyl, M.S. DARE To Be You Colorado State University 215 N. Linden, Suite E Cortez, CO 81321

E-mail: darecort@coop.ext.colostate.edu

Phone: 970.565.3606 Fax: 970.565.4641

BEST PRACTICE: Economic Interventions (Increasing Taxes)

Description of Best Practice

(Excerpts from Reducing Tobacco Use Among Youth: Community-Based Approaches: A Guideline for Prevention Practitioners, Center for Substance Abuse Prevention, 1997, Prevention Enhancement Protocols System Series 1, pp. 9-10 and from Alcohol Alert, National Institute on Alcohol Abuse and Alcoholism, October 1996, No. 34, PH 370.)

The primary goals of economic interventions as a prevention approach are to raise the price of tobacco and alcohol products through increased taxes and thereby prevent youth from taking up smoking and drinking, delay the age at which they might begin, and decrease the level of consumption.

Activities include an increase in taxes on cigarettes and alcohol through state legislation, and an increase in taxes on cigarettes and alcohol through the federal legislative pro-

Risk Factors Addressed

Availability of drugs Community laws and norms

Protective Factors Addressed

Healthy beliefs and clear standards

CSAP Strategy

Environmental

Type of Strategy

Universal

Populations Appropriate for This Best Practice

Studies not done with specific populations

Evaluating This Best Practice

The following are suggested areas to assess when implementing this practice:

- Assess the number and type of policies that related to the taxation of alcohol and tobacco
- · Assess decrease in alcohol and tobacco use by youth

Research Conclusions

Of the studies reviewed and summarized in Reducing Tobacco Use Among Youth: Community-Based Approaches: A Guideline for Prevention Practitioners (see below), there is "strong" evidence that instituting tobacco tax increases is an effective approach to reduce the prevalence of adolescent tobacco use — especially when the tax is sufficiently high and is linked to the consumer price index. NIAAA's Alcohol Alert cited research that found that alcohol taxes and prices affect alcohol consumption and associated conse-

Contact Information

For information on how to increase alcohol taxes in your state/community, obtain a copy of State Alcohol Taxes & Health: A Citizen's Action Guide from Center for Science in the Public Interest. Portions of the publication are available on our web site:

http://www.cspinet.org/booze/taxguide/tax_toc.htm

or obtain a copy from:

1875 Connecticut Avenue NW, Suite 300 Washington D.C. 20009-5728

Phone: 202.332.9110, x 385

The cost is \$10 plus shipping and handling.

Note: For more information on this best practice, order a free copy of the following publications from SAMHSA's National Clearinghouse for Alcohol and Drug Information (NCADI).

Phone: 800.729.6686, or Web site: http://ncadi.samhsa.gov

Reducing Tobacco Use Among Youth: Community-Based Approaches, Center for Substance Abuse Prevention, 1997, Prevention Enhancement Protocols System Series 1, publication order no. "PHD 745" (for prevention practitioners guide) and "PHD 746" (full document).

To obtain a copy of Alcohol Alert, National Institute on Alcohol Abuse and Alcoholism (NIAAA) No. 34, PH 370, October 1996, view the full text at the web site:

http://www.niaaa.nih.gov

or contact NIAAA at: Phone: 301.443.3860

BEST PRACTICE: (CICC's) Effective Black Parenting Program

Description of Best Practice

(Excerpt from *Strengthening America's Families: Promising Parenting Strategies for Delinquency Prevention, Office of Juvenile Justice and Delinquency Prevention, 1993, pp. 34-35.)*

Program Origin

This program was developed by the Center for the Improvement of Child Caring (CICC) in response to the criticism in the late 1970's that none of the widely used parent training programs in the U.S. were created specifically for African American Parents. In 1985, the Effective Black Parenting Program was developed that integrated all of the research findings and field test results.

Program Objectives

This cognitive-behavioral program is designed to foster effective family communication, healthy African American identity, extended family values, child growth and development, and healthy self-esteem. It is designed to facilitate community efforts to combat child abuse, substance abuse, juvenile delinquency, gang violence, learning disorders, behavior problems, and emotional disturbances.

Program Strategies

Effective African American Parenting is based on a pro-social achievement orientation to African American parenting and recognizes the special street pressures in inner city African American communities that make it difficult for African American parents to maintain such an orientation.

Two major parenting strategies are presented, The Family Approach for Developing Respectful Behaviors (utilizing family rules and family rule guidelines) and the Thinking Parent's Approach to Disrespectful Child Behaviors (utilizing systematic decision making processes).

The program teaches rule development, family meeting and problem assessment skills, and shares basic child development information to help parents make age appropriate rules, and several basic child management skills: effective praise, mild social disapproval, systematic ignoring, time out, and special incentives.

The regular program consists of 14 three-hour training sessions and a fifteenth session for a graduation ceremony. Each training session includes an extensive review and role playing of ideas and skills which were taught in previous sessions. Optimal group size appears to be about 15 to 20 parents, but more could be accommodated if necessary. A one-day seminar version of the program can be conducted for 50 to 500 parents.

Resources Needed and Materials Available

Materials include an instructor's manual, instructional charts, a parent's notebook, a promotional video, promotional flyers, and graduation certificates. Three supplementary books are available.

Special Characteristics

This program includes discussion of traditional African American discipline and contrasts this with modern African American discipline strategies in teaching parents new skills. Issues relevant to African American pride and ways of coping with racism are addressed. Child abuse information is included in a discussion of the disadvantages of using corporal punishment as a disciplinary technique.

Risk Factors Addressed

Family management problems

Protective Factors Addressed

Bonding: Family, Community

CSAP Strategy

Information dissemination Education Type of Strategy Universal

Populations Appropriate for This Best Practice

African American parents of children two- to 12-years-old

Evaluating This Best Practice

This best practice comes with an evaluation tool that can be used when implementing this strategy. There is no cost for the tool.

The following is a suggestion of an area you may want to assess if you implement this best practice:

Assess the increase in family management skills

Research Conclusions

(Excerpt from *Strengthening America's Families: Promising Parenting Strategies for Delinquency Prevention, Office of Juvenile Justice and Delinquency Prevention, 1993, p. 35.)*

Field test results indicate that:

- The program in its fully integrated form has direct and positive effects on many of the family and child risk factors that have been found through research to put children at risk for drug abuse, delinquency, and other social and health problems
- It reduces negative family communication
- · Enhances parental involvement with children
- · Reduces child behavior problems
- · Enhances limit-setting
- Improves the general psychological well-being of parents

Costs as of December 2001 (Subject to Change)

Training Time: Five full days of intensive training

Training Cost: \$925 per participant.

Note: Enrollment fee includes the cost of the Instructor's Kit (\$413). Workshops are led by professionals who are African American.

Strategy Implementation: \$23 per participant for the Parent Handbook

Special Considerations

Please consider the following before selecting this strategy for your community:

- It is important for instructors to receive training before starting to implement the program.
- Utilize multi-media strategies for recruiting parents the traditional media, organizations that parents are related to, and one-on-one requests for participation.
- Use many participation incentives, including refundable reservation or enrollment fees, free items earned as a result of regular attendance, etc.

Contact Information

For more information visit web site: http://www.ciccparenting.org

For additional information on training, technical assistance, and materials contact:

Norma Paniagua

818.980.0903 Phone:

For additional program information contact:

Kerby T. Alvy, Ph.D.

Center for the Improvement of Child Caring

11331 Ventura Blvd., Suite 103

Studio City, CA 91604

E-mail: kalvy@aol.com Phone: 818.980.0903 Fax: 818.753.1054

BEST PRACTICE: Families and Schools Together

Description of Best Practice

(Excerpt from *Strengthening America's Families: Promising Parenting Strategies for Delinquency Prevention, Office of Juvenile Justice and Delinquency Prevention, 1993, p. 49-50.)*

Program Objectives

The FAST program is designed to:

- (1) Enhance family functioning by strengthening the parentchild relationship in specific ways and empowering the parents to become primary prevention agents for their own children.
- (2) Prevent the target child from experiencing school failure by improving the child's behavior and performance, empowering parents as partners in the education process, and increasing family feelings of affiliation with their schools.
- (3) Prevent substance abuse by the child and the family members by increasing knowledge and awareness of substance abuse and its impact on child development, and linking the family to assessment and treatment services if necessary.
- (4) Reduce the everyday stress that parents and children experience by developing an ongoing support group for parents of at-risk students, linking participants to needed resources, and building the self-esteem of each family member.

Program Strategies

FAST uses a collaborative, whole family approach to achieve its goals. An eight-week curriculum for the Elementary School program (10-week for Early Childhood, 14-week for Middle School Program) of multiple-family group activities, followed by ongoing monthly meetings, incorporates the following activities: a meal hosted by a family, a family singalong, structured family communication exercises, family feelings identification exercises, parent support meetings while children play, one-to-one quality time, winning-as-afamily-unit exercises, a closing ritual, a substance abuse education component, graduation, and development of a school-based parent advisory council of FAST program graduates.

Recruitment and Retention

FAST identifies participants through a strong and active recruitment process in which school personnel identify at-risk children. Other recruitment activities include home visits and training in recruitment, plus a positive non-stigmatizing programmatic approach that focuses on strengths and empowerment incentives, and removal of obstacles to participation through provision of transportation and childcare. Of families initially telephoned by schools, 63 percent agreed to attend at least one meeting. Eighty-two percent of families that attend at least one meeting graduate from the FAST program. Recruitment and retention rates reflect first-time implementation at new sites; rates at ongoing sites are typically substantially higher.

Staffing

FAST is a collaborative effort between a school, a mental health agency, an alcohol and other drug abuse prevention specialist, and parents. Multifamily group meetings are staffed by a school staff member such as a social worker, counselor, psychologist or principle; a parent, liaison worker, or FAST facilitator; an alcohol and other drug abuse prevention specialist; and a mental health professional. Volunteers are recruited and trained to help at meetings.

Resources Needed and Materials Available

Necessary resources include a large room and materials to execute family activities. The FAST Program Manual describes all the resources needed to initiate the program. Please contact FAST for information on program planning, implementation, budgets, team training, and certification.

Special Characteristics

FAST targets whole families, reaches "unreachable" families, and uses a truly collaborative approach. FAST breaks down barriers to trust and stereotypes and promotes development of active parent groups and advocacy councils. FAST utilizes a stress/social-support model that builds on family strengths. FAST is explicit about program values. The FAST program model and activities are strongly grounded in an empirical research base.

Comments on Implementation/Replication

FAST has been successfully replicated in 39 states and five countries with rural, medium-sized, and urban communities. FAST groups have been made up of culturally diverse families, as well as solely Spanish-speaking people, Native Americans, African Americans, Asian Americans, or European Americans. FAST has developed a thorough and highly effective training model that includes links between communities and onsite training of collaborative teams.

Risk Factors Addressed

Family management problems
Parental attitudes and involvement
Low commitment to school

Protective Factors Addressed

Bonding: Family and School

CSAP Strategy

Information dissemination Education Problem identification and referral

Type of Strategy

Selective

Populations Appropriate for This Best Practice

 Preschool, elementary, and middle-school aged children whom teachers have identified as at risk for later problems and their families

- Infants and toddlers
- African American
- Native American
- Caucasian
- Hispanic/Latino
- · Rural, medium-sized, and urban communities

Evaluating This Best Practice

This best practice uses evaluation tools that are processed to create a final report.

Final Evaluation Report Cost:

\$1,000 per cycle. Evaluation process includes use of questionnaires, data entry, processing, final evaluation report.

The following are suggested areas to assess when implementing this practice:

- Assess improvements in child behavior problems
- Assess improvements in family cohesion
- · Assess increases in involvement of parents with their children's schools
- · Assess improvements in family management skills

Research Conclusions

(Excerpt from Strengthening America's Families: Promising Parenting Strategies for Delinquency Prevention, Office of Juvenile Justice and Delinquency Prevention, 1003, p. 50.)

Scores on objective, standardized assessment instruments demonstrate significant:

- Pre- to post-program improvements in child behavior problems, as rated by both parents and teachers
- · Improvements in family cohesion
- Decreases in social isolation of parents
- Increases in involvement of parents with their children's schools.

Collaborative teams rate the program as very successful. Data have been collected on over 700 elementary school children, and continuing evaluations of program effectiveness are in progress.

Costs as of December 2001 (subject to change)

Training Time: Approximately 25 hours Training Costs: Approximately \$9,000

Note: This cost pertains to elementary program training fees. It includes program manuals for team members, phase 1 training box with all paper materials needed for team training, final evaluation report, and certified FAST Trainer for five site visits. (You will also need to budget for trainer's travel cost/lodging/meals/per diem.)

Strategy Implementation:

\$2,500 per family, averaging 10 families per session

Special Considerations

Please consider the following before selecting this strategy for your community:

· A packet of information is available addressing considerations for implementing the FAST program, including such issues as how to set up teams and how to find a location. The packet can be ordered by calling toll free 888.629.2481.

Contact Information

Pat Davenport, Executive Director **FAST National Training and Evaluation Center** P.O. Box 14500 Madison, WI 53704

E-mail: fast@chorus.net Phone: 608.663.2382 or 888.629.2481

608.663.2336

Fax:

Web site: http://www.wcer.wisc.edu/FAST

BEST PRACTICE: Family Advocacy Network

(FAN CLUB) (CSAP Demonstration Grant #1383)

Description of Best Practice

(Excerpt from *Understanding Substance Abuse Prevention* — *Toward the 21st Century: A Primer on Effective Programs*, Center for Substance Abuse Prevention, unpublished document.)

In conjunction with the SMART Moves three-year youth drug prevention program [see description below], a parent involvement program called the Family Advocacy Network (FAN Club) was implemented for parents of prevention program youth at the four Boys & Girls Clubs serving as demonstration sites. The goal of the FAN Club was to strengthen families in the program by creating a bond between youth and their parents, reducing maternal isolation, providing opportunities for families to participate in pleasurable activities together, helping parents influence their children to lead drug-free lives, and providing social and instrumental support for families.

The FAN Club was designed to focus on families' strengths rather than deficits, to inspire parental confidence and competence, to respond to family cultural preferences and values, to recognize the developmental needs of parents, to be flexible and responsive to parental needs, to encourage voluntary participation by parents, and to include parents as partners in the planning and implementation of the program.

The three-year youth drug prevention program [mentioned above] consisted of the Start SMART and Stay SMART programs, components of Boys & Girls Clubs of America's National Prevention Program (SMART Moves), and SMART Leaders, developed by the investigators. These sequential programs were found effective in a previous CSAP grant. (See SMART Moves.)

Start SMART (10 sessions; 1-1/2 hours) Stay SMART (12 sessions; 1-1/2 hours) and SMART Leaders (5 sessions; 1-1/2 hours) are curriculum-based programs that use role playing, group activities, and discussion to promote social skills, including peer resistance skills, problem solving/decision-making skills, conservative group norms regarding substance use, and knowledge of the health consequences and prevalence of alcohol, tobacco, and other drug (ATOD) use by youth and adults. To continue in the three-year sequential program, youth were required to participate in 75% of the sessions in each program. Each year, when structured prevention program sessions were not taking place, program youth participated in monthly activities designed to stress nondrug use norms and to keep the youth involved in the prevention program.

Risk Factors Addressed

Favorable attitudes toward drug use

Protective Factors Addressed

Healthy beliefs and clear standards Skills: Social competence

Bonding: Family

CSAP Strategy

Information dissemination Education

Type of Strategy

Selective

Populations Appropriate for This Best Practice

- 11 to 15 years old and families
- African American
- Hispanic
- Caucasian

Evaluating This Best Practice

The following are suggested areas to assess when implementing this practice:

- · Assess perceived benefits from using marijuana
- · Assess ability to refuse alcohol, tobacco, and marijuana

Research Conclusions

(Excerpt from *Understanding Substance Abuse Prevention – Toward the 21st Century: A Primer on Effective Programs, Center for Substance Abuse Prevention, unpublished document.)*

Results from the youth self-report questionnaire indicated positive program effects for youth in Boys & Girls Clubs that offered the three-year youth prevention program with monthly youth activities and the FAN Club parent program (FAN Club group). Over the three years, the FAN Club group reported increasing ability to refuse alcohol, marijuana, and cigarettes, and increasing negative attitudes toward marijuana use.

Costs and Special Considerations

Please inquire of the contact below

Contact Information:

For more information on this program, visit web site: http://modelprograms.samhsa.gov

For materials, contact Supply Services at:

Phone: 404.487.5701

For training and technical assistance, contact CSAP at:

Phone: 877.773.8546

Mylo Carbia Boys & Girls Clubs of America 1230 W Peachtree St. NW Atlanta, GA 30309-3447

E-mail: mcpuig@bgca.org
Phone: 404.487.5766
Fax: 404.487.5789

Web site: http://www.bgca.org

BEST PRACTICE: Family Effectiveness Training

Description of Best Practice

(Excerpts from materials provided by the Center for Family Studies, University of Miami.)

The University of Miami, School of Medicine, Department of Psychiatric and Behavioral Sciences, established the Spanish Family Guidance Center in Miami in the 1970s to provide services to the local Hispanic community, which was predominately Cuban. The Spanish Family Guidance Center's work has grown in response to the needs of the minority community in Miami. In particular, work with youth with behavior problems has expanded to include minority families from a variety of backgrounds, including both Hispanic (from the Caribbean Islands and Central and South America) and African American youth and families.

To accommodate this expansion, the Center for Family Studies was established as an umbrella organization to serve inner-city minority youth and families in Miami. The mission of the Center for Family Studies is to identify the needs of minority families and develop and refine culturally appropriate interventions to meet those needs. The Center for Family Studies combined Brief Strategic Family Therapy and Bicultural Effectiveness Training into a package called Family Effectiveness Training.

Brief Strategic Family Therapy (BFST)

The Center for Family Studies uses BSFT to help children and adolescents with conduct, delinquency, and other behavior-related problems, including alcohol and substance abuse. To improve youth behavior, BSFT attempts to change family interactions and cultural/contextual factors that influence youth behavior problems. BSFT is based on the fundamental assumption that the family is the "bedrock" of child development; the family is viewed as the primary context in which children learn to think, feel, and behave. Family relations are thus believed to play a pivotal role in the evolution of behavior problems and, consequently, they are a primary target for intervention.

BSFT recognizes that the family itself is part of a larger social system and - as a child is influenced by her or his family - the family is influenced by the larger social system in which it exists. At the broadest level, BSFT recognizes the influence of cultural factors in their development and maintenance of behavior problems.

Bicultural Effectiveness Training

The center for Family Studies developed the bicultural effectiveness training intervention to enhance bicultural skills in all family members. Bicultural effectiveness training is specifically designed to ameliorate the acculturation-related stresses confronted by two-generation immigrant families (Szapocznik, Santisteban, et al., 1984). A clinical trial investigated the relative effectiveness of bicultural effectiveness training in comparison to BSFT (Szapocznik, Santisteban, Rio, Perez-Vidal, Krutines, & Hervis, 1986) in improving behavior problems in early adolescence and family functioning. The results of this study indicated that bicultural effectiveness training was as effective as structural family therapy in improving adolescent and family functioning.

Family Effectiveness Training

Subsequently, BSFT and bicultural effectiveness training were combined into a package called Family Effectiveness Training (Szapocznik, et al., 1986). A study investigated the effectiveness of family effectiveness training as a prevention/ intervention strategy for Hispanic families of children 6-11 who presented emotional and behavioral problems (Szapocznik, Santisteban, et al., 1989).

The results of this study indicated that families in the Family Effectiveness Training treatment group showed significantly greater improvement than did control families on measures of family functioning, problem behaviors, and child self-concept. Thus, the intervention was able to improve both child and family functioning. The improvements were still in effect at six-month follow-up.

Risk Factors Addressed

Family conflict Antisocial behavior

Protective Factors Addressed

Skills: Parenting

CSAP Strategy

Education Information dissemination

Type of Strategy

Selective

Populations Appropriate for This Best Practice

- Hispanic parents of children exhibiting problems
- · African American parents of children exhibiting problems

Evaluating This Best Practice

The following are suggested areas to assess when implementing this practice:

- Assess the change in level of conflict in the family.
- · Assess the level of problem behaviors in the children of participating parents.

Research Conclusions

(Excerpts from materials provided by the Center for Family Studies, University of Miami.)

Results indicate that families in the FET Program showed significantly greater improvement than did control families on independent measures of structural family functioning, on problem behaviors as reported by parents, and on a selfadministered measure of child self-concept. Furthermore, the results of the follow-up assessments indicated that the effects of the FET intervention were maintained over time.

Costs and Special Considerations

Please contact the Center for Family Studies for information on costs and special considerations.

Contact Information

For technical assistance, training and materials:

Carleen Robinson Batista University of Miami Center for Family Studies 1425 NW 10th Avenue, 3rd Floor Miami, FL 33136

Wildilli, FL 33130

E-mail: crobins2@med.miami.edu

Phone: 305.243.4592 Fax: 305.243.5577

BEST PRACTICE: Family Therapy 47

BEST PRACTICE: Family Therapy (General)

Description of Best Practice

(Excerpt from Family Centered Approaches, Center for Substance Abuse Prevention, 1998, Prevention Evaluation Protocols System, pp. 18-19.)

This prevention approach targets families at high risk because they face multiple risk factors or have a high level of exposure to a particular risk factor. The interventions in this approach are designed to improve family functioning and reduce juvenile delinquency, recidivism, child abuse, and other strong antisocial behaviors.

Family therapy helps family members develop interpersonal skills and improve communication, family dynamics, and interpersonal behavior. It can be used to help family members improve their perceptions about one another, decrease negative behavior, and create skills for healthy family interaction. It can also be used to enhance parenting skills and reduce inappropriate parental control over children.

Expected Changes and Key Activities

The expected changes in this prevention approach all focus on improving family functioning and reducing children's recidivism and other problem behaviors. All activities focus on changes in:

- 1. Families Increasing mutual positive reinforcement and decreasing maladaptive interaction patterns, improving family dynamics in families with juvenile offenders or adolescents with strong antisocial behaviors, acquiring skills, improving communication, learning effective discipline methods, and learning self-management skills.
- 2. Youth Reducing behavioral and emotional problems and repeat offender rates, improving the functioning of juvenile offenders, and preventing the initiation of substance abuse.

Activities include various types of family-centered therapies used with diverse groups of clients. The following illustrate some of the therapies and groups treated:

- 1. Functional family therapy, used by paraprofessional therapists and foster care caseworkers for families with seriously delinquent youth (Alexander and Parsons 1982)
- 2. Structural family therapy, used for Hispanic families with boys diagnosed as having opposition disorder, conduct disorder, adjustment disorder, or anxiety disorder (Santisteban et al. 1995)
- 3. Multi-systemic family-ecological therapy for families with juvenile offenders (Henggeler et al. 1986; Henggeler, Melton, and Smith 1992)

Risk Factors Addressed

Persistent antisocial behavior Family management problems

Protective Factors Addressed

Bonding to family

CSAP Strategy

Education

Information dissemination

Type of Strategy

Indicated

Populations Appropriate for This Best Practice

Not defined

Evaluating This Best Practice

The following are suggested areas to assess when implementing this practice:

- · Assess the level of communication between parent-child
- · Assess family management skills
- Assess parental knowledge about how to reduce antisocial child behavior
- Assess level of family bonding, including perceptions and attitudes of parents and adolescents about each other

Research Conclusions

(Excerpt from Family Centered Approaches, Center for Substance Abuse Prevention, 1998, Prevention Evaluation Protocols System, p. 19.)

The research and practice evidence reviewed indicates that it is possible to implement family therapy for families with children who are at high risk of substance abuse:

There is medium evidence that family therapy results in enhanced parenting skills, improved family communication, increased parental knowledge about how to reduce antisocial child behavior, improved perceptions and attitudes of parents and adolescents about each other, and reduced inappropriate control of parents over adolescents.

There is strong evidence that family therapy reduces recidivism in delinquent teenagers.

Note: The criteria used to rate the strength of evidence for each prevention approach are shown in Appendix A [in the source document].

Contact Information

For more information, order a copy of CSAP's Family Centered Approaches from:

National Technical Information Systems

Phone: 800.553.6847

Practitioners Guide cost: \$29.50, order #PB 98159692 Reference Guide cost: \$58.00, order #PB 99101800

BEST PRACTICE: Focus on Families

(Catalano et al)

Description of Best Practice

(Excerpt from *Preventing Drug Use Among Children and Adolescents*, National Institute on Drug Abuse, 1997, pp. 26-27.)

A program for parents receiving methadone treatment and for their children, Focus on Families has a primary goal to reduce parents' use of illegal drugs by teaching them skills for relapse prevention and coping. Parents are also taught how to manage their families better. The parent training consists of a 5-hour family retreat and 32 parent training sessions of 1.5 hours each. Children attend 12 of the sessions to practice developmentally appropriate skills with their parents.

Session topics include:

- Family goal-setting
- Relapse prevention
- · Family communication
- · Family management
- Creating family expectations about alcohol and other drugs
- Teaching children skills (such as problem-solving and resisting drug offers)
- · Helping children succeed in school

Booster sessions and case-management services also are provided.

Risk Factors Addressed

Family management problems
Parental attitudes and involvement

Protective Factors Addressed

Skill building Bonding: Family

CSAP Strategy

Information dissemination Education

Type of Strategy

Selective

Populations Appropriate for This Best Practice

Parents receiving methadone treatment and their children

Evaluating This Best Practice

This best practice does not come with an evaluation tool that can be used when implementing this strategy. However, comprehensive tools are available at an approximate copying cost of \$50.00. Data analysis is not provided.

The following are suggested areas to assess when implementing this practice:

- · Determine a decrease in parents' drug use
- · Determine an increase in parenting skills

Research Conclusions

(Excerpt from *Preventing Drug Use Among Children and Adolescents*, National Institute on Drug Abuse, 1997, p. 27.)

Early results indicate that parents' drug use is dramatically lower and parenting skills significantly better than are seen in control groups; the program's effects on children have not yet been assessed, however.

Costs as of May 2001 (Subject to Change)

Training Time: When available, it is anticipated to be 24 hours.

Training Costs: Undetermined

Note: Training is under development through THS Training Institute, Seattle, Washington. The training will provide specific skills for working with the population and with direct issues of program implementation.

Strategy Implementation (1996 costs): \$3,444 per client family

This includes the cost of staff, childcare providers, office rent, telephone, travel, photocopy and other consumable supplies, and participant incentives.

Special Considerations

Please consider the following before selecting this strategy for your community:

- This is a program that is targeted at parents in methadone treatment.
- It requires role-playing and videotape and comprehensive case management.
- It is more than just buying a curriculum and implementing it. It is making family a part of the treatment process and working with drug abusers on parenting skills.

Contact Information

For training, materials and technical assistance:

Raymond Hummel

Therapeutic Health Services Training Institute

Phone: 206.323.0930

For additional program information, visit web site: http://depts.washington.edu/sdrg

Or contact:

Kevin Haggerty Social Development Research Group University of Washington 9725 3rd Ave NE, Suite 401 Seattle, WA 98115-2024

E-mail: haggerty@u.washington.edu

Phone: 206.543.3188 Fax: 206.543.4507

BEST PRACTICE: Functional Family Therapy

(Alexander and Parsons)

Description of Best Practice

(This excerpt provided by the Functional Family Therapy Project, November 2000.)

Functional Family Therapy (FFT) is well-documented family prevention and intervention program that has been applied successfully to a wide range of problem youth and their families in various contexts. Functional Family Therapy (FFT) is an empirically grounded intervention program that targets youth between the ages of 11 and 18, although younger siblings of referred adolescents also benefit from the program.

FFT is a short-term intervention with sessions from, on average, 8 to 12 one-hour sessions for mild cases and up to 26-30 hours of direct service for more difficult situations. In most programs sessions are spread over a three-month period of time.

Target populations range from at-risk preadolescents to youth with very serious problems (such as conduct disorder) youth representing multi-ethnic, multicultural populations. FFT has been successful with a range of delinquent and substance abusing youth.

The data from numerous outcome studies suggests that when applied as intended, FFT can reduce recidivism between 25% and 60%. Additional studies suggest that FFT is a cost-effective intervention that can, when appropriately implemented, reduce treatment costs well below that of traditional services and other family-based interventions.

The major goals of Functional Family Therapy are to:

- Engage and motivate youth and their families by decreasing the intense negativity so often characteristic of these families
- 2) Reduce and eliminate the problems behaviors and accompanying family relational patterns that put family and youth at risk through individualized behavior change plans that target the improvement of family communication, parenting, and problems solving skills
- Generalize changes across problem situations by increasing the family's capacity to adequately utilize community resources

The FFT model is appealing because of its clear identification of specific intervention phases, each with a description of goals, requisite therapist characteristics, and techniques. The phases of interventions help organize therapy into a coherent manner allowing clinicians to maintain focus in the context of considerable family and individual disruption.

Each phase includes specific goals, assessment foci, specific techniques of intervention, and therapist skills. Through these phases, FFT combines a strong cognitive/attributional component, which is integrated into systematic skill-training in family communication, parenting, and conflict management skills.

As a clinical model FFT has been conducted in clinical settings as an outpatient therapy and in clients homes as a home-based model. The fidelity of the FFT model is achieved by a specific training model and a sophisticated client assessment, tracking, and monitoring system that provides for specific clinical assessment and outcome accountability. The FFT Practice Research Network (FFT-PRN) allows clinical sites to participate in the development and dissemination of FFT model information.

Risk Factors Addressed

Family management problems Family conflict Persistent antisocial behavior

Protective Factors Addressed

Bonding: Family

CSAP Strategy

Information dissemination Education

Type of Strategy

Indicated

Populations Appropriate for This Best Practice

First time delinquent and pre-delinquent youth

Evaluating This Best Practice

This best practice comes with an evaluation tool that can be used when implementing this strategy.

Evaluation Tool Cost:

The tool is included in the overall training cost. Sites are required to purchase the POSIT (\$75 CD-ROM) the FAM-III (\$25 for 25 forms) and the limited OQ.45 site license (\$15 for 15 people, \$8 for each additional manual and \$500 license fee). The CSS is a computer-based monitoring and tracking tool to be used in measuring adherence and clinical outcomes. Outcome measures are built into this system.

The following are suggested areas to assess when implementing this practice:

- · Assess decreased recidivism rate
- · Assess increased parental skills
- · Assess decreased family conflict

Research Conclusions

(Excerpt from Strengthening America's Families: Promising Parenting Strategies for Delinquency Prevention, Office of Juvenile Justice and Delinquency Prevention, 1993, page 68.)

The program has demonstrated impact on reducing delinquency in targeted teenagers and 18 month follow-up studies suggest that the impact is lasting. The program has a preventive influence on the younger siblings. It is one of the few family-focused programs which has been tested for effectiveness with adolescent status-offenders.

Costs as of December 2001 (Subject to Change)

Training Time: Site certification is a one-year process

Training Costs:

\$24,500 per site for entire training package plus travel expenses

Note: The standard training program targets working groups at community implementation sites. FFT has a three-phase certification process usually lasting three years. Site certification is required of community agencies hoping to implement FFT as a clinical model. Potential sites need to submit an application for site certification. (Please see "Special Considerations.")

Strategy Implementation:

\$2,000 per family. Sites are required to purchase the POSIT, the FAM-III, and the limited OQ.45 site license. These costs are minimal.

Special Considerations

Please consider the following before selecting this strategy for your community:

- FFT can be delivered as an in-home or in-office intervention
- Certification allows both individuals and sites to participate in ongoing research, training, and service implementation activities.
- Site certification is a one-year process involving:
 - Three-day clinical training for all FFT therapists in a working group
 - Externship training for one working group member (will become the clinical lead for the working group)
 - Follow-up visits (usually three, one to two days onsite)
 - Supervision Consultations (four hours of monthly phone consultation)
 - · Clinical Services System

Contact Information

For more information on Functional Family Therapy, visit web site:

http://www.fftinc.com

For technical assistance, training and materials:

Kathie Shafer, Project Manager E-mail: shafer@csbs.utah.edu

Phone: 801.585.1807

For questions related to Functional Family Therapy, contact:

James F. Alexander, Ph.D. Department of Psychology University of Utah 390 S. 1530 E., Room 502 Salt Lake City, UT 84121

E-mail: jfafft@psych.utah.edu

Tom Sexton, Ph.D.

Department of Counseling and Educational Psychology

Indiana University 201 North Rose Avenue Bloomington, IN 47405

E-mail: thsexton@indiana.edu

Phone: 812.856.8350

For implementation and site certification contact:

Doug Kopp, National Implementation Director FFT Inc.

2538 57th Ave SW Seattle, WA 98116

E-mail: dkfft@msn.com

For a copy of the "Blueprint" summary for this program (step-by-step instructions that will help communities plan and implement youth crime and violence prevention strategies, Cost: \$15 per copy) contact:

Center for the Study and Prevention of Violence

Institute of Behavioral Science University of Colorado at Boulder

Campus Box 442

Boulder, CO 80309-0442 Phone: 303.492.8465

Web site: http://www.colorado.edu/cspv/blueprints

BEST PRACTICE: Healthy Families America 51

BEST PRACTICE: Healthy Families America

Description of Best Practice

(Excerpts from Strengthening America's Families' web site, http://www.strengtheningfamilies.org/index.html and updated with information from Prevent Child Abuse America's web site: http://www.healthyfamilisamerica.org/index.html)

Prevent Child Abuse America (PCA America), formerly known as the National Committee To Prevent Child Abuse, sponsors the Healthy Families America home visiting initiative in 420 sites across the nation. The Healthy Families is a voluntary home visitation program designed to promote healthy families and healthy children through a variety of services including child development, access to health care and parent education. The program serves families identified as at-risk, with children 0-5 years.

Program goals include prevention of negative birth outcomes (low birth weight, substance abuse, criminal activity, child abuse and neglect), increased parenting skills, healthy pregnancy practices, and the use of social systems. Assessments are conducted either prenatally or at the time of birth. Home visiting can begin either prenatally or within 90 days after birth. The Family Support Worker (FSW) visits at least once a week for up to one year. The FSW helps establish support systems, teaches problem-solving skills, enhances positive parent-child interaction, and offers information, education and referrals to community resources. Once a family is in the program, they can receive services for up to five years.

Risk Factors Addressed

Family management problems Constitutional factors

Protective Factors Addressed

Bonding - Family Skills - Parenting

CSAP Strategy

Problem identification and referral

Type of Strategy

Selective

Populations Appropriate for This Best Practice

- Parents with children ages 0-5, facing multiple challenges (e.g. elements that would add stressors to any home:
- · Single parent status
- Low income
- Substance abuse problems
- Victim of abuse or domestic violence, etc.

Evaluating This Best Practice

This best practice does not come with an evaluation tool that can be used when implementing this strategy. However, the credentialing process that Healthy Families America uses ensures fidelity of the implementation of the program.

The following are suggestions of areas you may want to assess if you implement this best practice:

- · Assess change in family management skills by parent participants
- Assess rate of child maltreatment by parent participants
- Assess level of positive parent-child interaction patterns in participant families

Research Conclusions

(Excerpt from Strengthening America's Families' web site, http://www.strengtheningfamilies.org/index.html)

In 1992, Healthy Families America moved forward with the home visiting model based on a comprehensive evaluation, using an experimental design that was conducted with 372 families in the Hawaii Healthy Start program. The results indicate that early and intensive home visitation by paraprofessionals produces measurable benefits for participants in the areas of parental attitudes toward children, parentchild interaction patterns, and type and quantity of child maltreatment. Mothers who received home visits significantly reduced their potential for physical child abuse and showed significant positive changes in maternal involvement and sensitivity to child cues. Treatment families exhibited more positive parent-child interaction patterns at both sixand twelve-month assessment points.

Please visit the following web site for information about training time and cost:

http://www.healthyfamiliesamerica.org/services/training.html

Implementation Cost:

Please contact the organization listed below for information on implementation cost.

Special Considerations

The following should be taken into consideration before selecting this strategy to be implemented in your community:

• An Application for Affiliation is completed by new programs to ensure that Healthy Families is a good fit for them and their community.

Please contact Healthy Families America for more information.

Contact Information

For more information on this program, visit web site: http://www.healthyfamiliesamerica.org and http://ojjdp.ncjrs.org/pubs/fact.html#fs200123 and (click on "Healthy Families America")

For technical assistance, training and materials, contact: Healthy Families America 200 S. Michigan Avenue, Suite 1700 Chicago, IL 60604

Phone: 312.663.3520 Fax: 312.939.8962

BEST PRACTICE: Home Instruction Program for Preschool Youngsters

Description of Best Practice

(Excerpt from materials provided by HIPPY USA.)

The Home Instruction Program for Preschool Youngsters (HIPPY) is a home-based parent involvement, school readiness program. It helps parents of three-, four- and five-yearold children prepare their children for success in school and beyond.

The two basic tenets of HIPPY are that:

- 1. All children can learn
- 2. All parents want what's best for their children

The HIPPY program is made up of four basic features:

- 1. The curriculum, which (for each year) includes: thirty weeks of activities (five days for each week) for parents to do with their children, nine storybooks and 20 manipulative shapes
- 2. The home visitors, who are paraprofessional staff and themselves parents in the program, supervised by a professional coordinator
- 3. Role-play as the method of teaching the curriculum, both when coordinators train home visitors and when home visitors work with parents
- 4. Home visits as the primary method of delivery, but with group meetings that allow parents to meet and discuss/ learn about common issues and children to interact with other children in a supervised environment

Parents of three- and four-year-old children are recruited into the program by the HIPPY coordinator, who chooses some of the parents to hire as home visitors. The home visitors "practice" doing HIPPY with their own child and then visit each of their case load of families (10-15 per part-time home visitor) on a bi-weekly basis, to role-play the upcoming week's curriculum, review the previous week's activities, and discuss any issues the parent may have. On the weeks when no home visit takes place, a group meeting is held and role-play of the curriculum takes place with parents as a group and then an enrichment activity (chosen by the parents) is conducted. Once the group meeting is over, or the home visit has taken place, the parent works, one-on-one, with his/her child for 15-20 minutes per day for five days.

The program started in Israel in 1969 and has since spread to Turkey, Germany, Chile, Mexico, New Zealand, South Africa and the United States (in 1984). Each country, culture and language makes its own adaptations to the HIPPY model, in order to implement it effectively in its community. However, the four features of the HIPPY model - the essence of the HIPPY program - remain the same. The implementation of the HIPPY model, and in particular the HIPPY curriculum, is continually updated and improved, based on relevant research and on feedback from program participants.

In program year 2000-2001, there were 161 HIPPY sites in 29 states, the District of Columbia and the Territory of Guam. HIPPY served 16,307 children with 892 home visitors. The racial/ethnic compositions of our service recipients were: 39% African American, 27% Caucasian, and 30% Hispanic/ Latino. A "typical" HIPPY program serves 150 families with one coordinator and 10-12 part-time home visitors. HIPPY USA is the national office for the network of HIPPY programs in the United States, with the primary responsibilities of providing training and technical assistance; developing and improving the curriculum and the implementation of the HIPPY model; outreach, advocacy and national collaborations; and national data collection and evaluation initiatives.

Risk Factors Addressed

Academic failure

Protective Factors Addressed

Skill building

CSAP Strategy

Education

Type of Strategy

Selective

Populations Appropriate for This Best Practice

Parents of three-, four-, and five-year-old children

Evaluating This Best Practice

This best practice does not come with an evaluation tool that can be used when implementing this strategy.

The following suggestion is an area you may want to assess if you implement this best practice:

· Assess academic performance of children after they are in elementary school

Research Conclusions

(Excerpt from Strengthening America's Families' web site, http://www.strengtheningfamilies.org/index.html)

Evaluations on classroom adaptation, paraprofessionals' growth and development, program implementation, model validation, and children's outcomes at end of second grade have all shown positive effects from participation in the program. Broad differences in measured competence and classroom behavior favoring HIPPY children over children with no formal preschool experience were found. There were no differences between HIPPY children and children with other types of formal preschool experience.

Costs as of December 2001 (Subject to Change)

Training Time: Five days

Training Costs:

- \$850 for the first person from an agency/organization
- \$600 for the second person from the same agency organization
- \$340 administrators/supervisors attending the training for two full days

The initial pre-service training is five days long and is required of all new coordinators and programs. On-going training and technical support is at the foundation of HIPPY. All coordinators have an assigned National Trainer to mentor and assist them. A national conference is held yearly and is attended by all coordinators, HIPPY USA staff, trainers, and many paraprofessionals.

Strategy Implementation:

HIPPY is estimated to cost \$500 - \$1,600 per child per year, based on average program size of 60 families in the first year and 120 families in the second year, a full-time coordinator and one paraprofessional for each group of 12 families. The 1999 - 2000 cost per child of implementing this strategy was \$1,267. Programs with low costs generally receive significant in-kind donations. Costs vary based on size and location, urban or rural settings.

These figures cover:

- · Salaries for staff
- · Fees for training and technical assistance
- · License and affiliation
- · Program development
- · Cost of curriculum materials
- Travel
- Conference attendance
- Supplies
- · Other direct costs

Curriculum materials may only be purchased once a formal contractual agreement has been signed with HIPPY USA. The HIPPY Start-Up Manual can be obtained free of cost, or a HIPPY order form by e-mail: info@hippyusa.org. The

manual provides detailed information on the steps to implementation, budget considerations and the application form.

Special Considerations

Please consider the following before selecting this strategy for your community:

- Additional trainings are offered by state and regional programs assisted by HIPPY USA staff and national trainers.
- Curriculum/materials are written on a third-grade reading level.
- · Curriculum is available in English and Spanish.
- HIPPY can be implemented in both urban and rural settings, in a variety of host agencies:
 - · Public schools
 - · Public housing projects
 - · Community-based service organizations
 - Universities

Contact Information

For outreach materials or more information, visit web site: www.hippyusa.org

For training information

M. Gayle Hart, Director of Training E-mail: mghart@hippyusa.org

Phone: 800.208.7228 For more information:

Melinda Devaney

HIPPY USA

220 East 23rd Street, Suite 300

New York, NY 10010

E-mail: info@hippyusa.org

Phone: 212.532.7730 Fax: 212.532.7899

BEST PRACTICE: Home Visiting

BEST PRACTICE: Home Visiting

Description of Best Practice

(Excerpt from *Preventing Crime: What Works, What Doesn't, What's Promising,* University of Maryland, Department of Criminology and Criminal Justice and the U.S. Department of Justice, Office of Justice Programs, 1997, pp. 4-10 through 4-15.)

Home visitation varies enormously in dosage levels, content, skill, and context. Yet there are common effects reported across all these variations. The common core of home visitation is a visitor who cares about child-raising sitting down in a home with a parent and a child. Visitors can be nurses, social workers, preschool teachers, psychologists, or paraprofessionals. They can provide cognitive information, emotional support, or both. They can actively teach parents, with hands on the children. Or they can passively watch and listen, merely giving parents a good listening to. They can be trained in health (like nurses), human development (like psychologists and social workers), cognitive and social skills instruction (like preschool teachers), or some mixture of these subjects (like paraprofessionals). They can be experienced or novice, enthusiastic or burned out, assertive or hesitant. But no matter who they are or what they do, they provide a bridge between the parent, usually a mother, and the outside world.

While the two long-term experiments included preschool programs (also called "day care" in some studies) positive effects were found in 11 of the experiments from home visitation without preschool. Some of the home visitations included doctor's office visits or some other contexts for instruction and observation outside the home, but most did not. None of the five experiments showing that home visitation reduced child abuse included involvement in preschool.

The consistent finding of beneficial effects of home visits without preschool is important for several reasons. One reason is theoretical: it shows that the visits are not simply a spurious correlate of the effects of preschool programs on both the children and their mothers, who in some studies are heavily involved in the preschool programs and who show beneficial effects themselves in reduced welfare support and longer time between pregnancies.

The fact that one trial (Wasik et al., 1990) found stronger effects from home visits with cognitively-oriented day care than from home visits to comparison families (of which more than half were in some other kind of day care) does not contradict the independent effects of home visits. Yoshikawa (1994) and others have concluded that home visits are likely to be more effective in combination with early education, but the empirical evidence may still be too preliminary to reach a conclusion either way.

(For a specific example of a home visiting program, see Prenatal/Early Infancy Project.)

Risk Factors Addressed

Family management problems

Protective Factors Addressed

Bonding: Family Opportunities and skills

CSAP Strategy

Information dissemination Education

Type of Strategy

Universal

Populations Appropriate for This Best Practice

- · Low income
- Caucasian
- African American
- Hispanic/Latino
- · Children of high-risk mothers

Evaluating This Best Practice

The following are suggested areas to assess when implementing this practice:

- · Assess increased in family management skills
- · Assess increased family bonding
- · Assess decrease in child abuse rates

Research Conclusions

(Excerpt from *Preventing Crime: What Works, What Doesn't, What's Promising,* University of Maryland, Department of Criminology and Criminal Justice and the U.S. Department of Justice, Office of Justice Programs, 1997, pp. 4-10 through 4-15.)

Figure 4-2 [in *Preventing Crime: What Works, What Doesn't, What's Promising,* p. 4-11 through 4-14] summarizes the results of 18 different evaluations of programs that included a home visitation component. The figure and this discussion draws primarily on the material in Yoshikawa's (1994) review, as well as Tremblay and Craig's review (1995) and the draft OJJDP review prepared by Wasserman and Miller (forthcoming). All of them show positive effects of home visits on either some measure of crime by children when they enter adolescence (N = 2 experiments) child abuse during or shortly after the period of home visits (N = 5 experiments) or risk factors for delinquency (N = 10 experiments, 1 metanalysis).

While the meta-analysis of Head Start evaluations (McKey, et al., 1985) shows that the measured effects wear off, that analysis includes the lowest dosage of home visits of any of the experiments: as few as two per year. In contrast, the substantial reductions in later delinquency in the two long-term follow-up studies are associated with weekly home visits for periods up to five years.

Even if home visits were more effective in combination with other prevention efforts, the evidence of their independent effects has practical implications. The Hawaii State Healthy Start program, for example (U.S. Advisory Board, 1995: 129) which reaches more than half of all Hawaiian newborns, operates on a \$7 million annual budget as a home visit program only. The evidence reviewed in figure 4-2 suggests that the Hawaiian program is likely to be effective at reducing child abuse, as would Federal funding of home visit programs nationally. Whether they would be effective at preventing delinquency or serious crime in later life by the children visited cannot be determined without longer-term studies.

Child abuse and neglect is a risk factor for delinquency, however, associated in one prospective study with a 50 percent increase in prevalence and a 100 percent increase in frequency of adolescent arrests (Widom, 1989). Thus, if the results of the home visitation experiments can be generalized to other settings, they could clearly reduce a delinquency risk factor. The effect sizes in these evaluations are particularly impressive. Both of the long-term delinquency prevention effects are on the magnitude of a relative reduction of three-quarters less prevalence of official criminal histories.

Costs and Special Considerations

Not available

Contact Information

For more information on this best practice, you can order a free copy of *Preventing Crime: What Works, What Doesn't, What's Promising,* University of Maryland/Department of Criminology and Criminal Justice and the U.S. Department of Justice/Office of Justice Programs, 1997, from:

National Criminal Justice Reference Service

Phone: 800.851.3420

For a copy of a summary of the "Blueprint" for this program (step-by-step instructions that will help communities plan and implement youth crime and violence prevention strategies, Cost: \$10 per copy) contact:

Center for the Study and Prevention of Violence Institute of Behavioral Science University of Colorado at Boulder Campus Box 442

Boulder, CO 80309-0442 Phone: 303.492.8465

Web site: http://www.colorado.edu/cspv/blueprints

BEST PRACTICE: Home-Based Behavioral Systems Family Therapy

Description of Best Practice

(Excerpt from Strengthening America's Families' web site, http://www.strengtheningfamilies.org/index.html and updated by Don Gordon in December 2001.)

This program's long-range objectives include:

Reduced child involvement in juvenile justice system

Reduced self-reported delinquency

Reduced teen pregnancy

Reduced special class placement

Increased graduation rates

Increased employment

Intermediate objectives include:

Decreased family conflict

Increased cohesion

Improved communication

Improved parental monitoring, discipline, and support

of appropriate child behavior

Improved problem solving abilities

Improved parent-school communication

Improved school attendance and grades

Improved child adjustment

Dr. Gordon's model has been applied to multiply offending, institutionalized delinquents, and targets families with low educational levels and high levels of pathology. Modifications were made for families in Appalachia and for innercity African American families.

The program is delivered in 5 phases:

- 1. Introduction/Credibility
- 2. Assessment
- 3. Therapy
- 4. Education
- 5. Generalization/Termination

In the early phases, therapists are less directive and more supportive and empathic than in the later phases, when the family's cooperation and resistance is more conducive to increased therapist directiveness. Percentage of therapist-family contact time devoted to each phase is approximately: 5 % Introduction; 15% Assessment; 45% Therapy; 25% Education; and 10% Generalization/Termination.

Risk Factors Addressed

Persistent antisocial behavior Family management problems Academic failure

Protective Factors Addressed

Bonding — Family

CSAP Strategy

Education

Type of Strategy

Indicated

Populations Appropriate for This Best Practice

- Institutionalized delinquent youth with multiple offenses and their families
- · Inner-city African American families
- · Families in Appalachia (a rural area)

Evaluating This Best Practice

The following are suggested areas to assess when implementing this practice:

- · Assess change in family management skills
- · Assess youth's recidivism rate
- Assess school attendance, grades, and graduation rates of youth participants
- · Assess family cohesion
- · Assess child behavior

Research Conclusions

(Excerpt from Strengthening America's Families' web site, http://www.strengtheningfamilies.org/index.html)

The first evaluation was based on treatment of twenty-seven 14- to 16-year-old, court selected delinquents who were considered likely to recidivate and/or to be placed out of the home.

After a two to two-and-a-half year follow-up period, recidivism for the treatment group was 11% vs. 67% for the control group. The subjects in this study were followed for another 32 months into adulthood. The treatment group showed a 9% recidivism rate for criminal offenses vs. 45% for the control group.

The second evaluation was conducted with forty juveniles referred to the treatment program because they were the most serious, chronic offenders in the county.

Upon an average of 18 months following the end of treatment, 30% of treated delinquents re-offended and 12% required another institutional commitment. A constructed statistical control group, based upon risk of recidivating, would be expected to have a 60-75% recidivism rate, and a recommitment rate of 50-60%. The large difference between actual and expected rates indicate a robust treatment effect, not due to chance.

Costs as of December 2001 (Subject to Change)

Strategy Implementation:

- Two therapist manuals, 170 and 38 pages, can be copied and cost \$11.50 for the two per trainee.
- In addition, parent workbooks for the Parenting Wisely program are given to each family treated. These workbooks (100 pages) that are used in the education phase, need to be ordered from Dr. Gordon, and cost \$9 each.
- Instructional videotapes for therapists are available at cost, approximately \$5 each for two.
- · A set of three parenting skill training tapes, the Parenting

Wisely video series, which can be used repeatedly, costs \$250.

For training costs, please contact Dr. Gordon.

Contact Information

For more information, visit:

Web site: http://www.familyworksinc.com

or contact:

Donald A. Gordon, Ph.D. Psychology Department Ohio University Athens, OH 45701

E-mail: gordon@ohiou.edu

Phone: 541.201.7680

BEST PRACTICE: Houston Parent-Child Development Center

Description of Best Practice

(Excerpts from information provided by Dale L. Johnson, Ph.D., Department of Psychology, University of Houston, Houston, TX)

The Houston Parent-Child Development Center was developed to assist low-income, Mexican American families in helping their children to do well in school and to foster intellectual and social competence. The program was designed to provide a wide range of educational and support services, to deliver these services in ways that were responsive to the families' poverty, and to be sensitive to their culture. Evaluation of the program has demonstrated success in reducing the incidence of behavior problems and enhancing school performances five to eight years after completion of the pro-

Elements of the two-year program include:

Year One

- In-Home Visits: 25 one and a half hour visits by paraprofessional educators teaching infant development topics.
- · Family Workshops on Sundays or Weekends: Small groups of differing configurations receive training on communication, decision making, and on issues suggested by participants.
- English as a Second Language: Classes for mothers and referrals for fathers.
- · Community Services: transportation to workshops, education on attaining resources, and information on family planning, child health and public health centers provided by a visiting nurse.

Year Two

- Center-Based Activities: 4 hours, 4 mornings a week for mothers and their two-year-old children, with transportation and lunch provided.
- · Child Care Management: Continuation of year-one topics in group discussion formats with greater emphasis on authoritative parenting and problem behavior management, and attaining feedback from participating parents who practiced newly learned skills.
- Home Management: Mothers learn skills in budgeting, meal planning, and on participant requested topics such as driver education and human sexuality.
- Nursery School: Two-year-olds are encouraged to explore and to develop new peer relationships.
- · Teachers stimulated cognitive development by posing questions and problem-solving situations.
- Parent Advisory Committee (PAC): monthly evening meetings for fathers result in successfully strong, active paternal roles.

Risk Factors Addressed

Early antisocial behavior Academic failure Family management problems

Protective Factors Addressed

Bonding: Family

Skills: Social competence

CSAP Strategy

Education

Type of Strategy

Selective

Populations Appropriate for This Best Practice

Low-income Mexican American families and their children ages birth to three

Evaluating This Best Practice

This best practice does not come with an evaluation tool that can be used when implementing this strategy.

The following is a suggested area to assess when implementing this practice:

Assess mother's use of praise, warmth, encouragement of child verbalization, and provision of a cognitively stimulating home environment

Research Conclusions

(Excerpts from information provided by Dale L. Johnson, Ph.D., Department of Psychology, University of Houston, Houston, TX)

A primary prevention program, the Houston Parent-Child Development Center, directed towards infants and their parents, has effectively reduced the frequency of behavior problems for these children five to eight years after the program's completion.

- · Teacher ratings showed significantly fewer acting-out, aggressive behaviors for program children.
- · Ratings of classroom behaviors found program children to be significantly less hostile and more considerate than control children.
- Program boys were less dependent than control boys.
- · Program children had higher school achievement test scores than control children and these differences persisted into high school.

Costs as of December 2001 (Subject to Change)

Training Time:

Variable, dependent upon individual implementation needs

Special Considerations

Please consider the following before selecting this strategy for your community:

• Manuals are available and consultation can be provided on their use.

Contact Information

For information, technical assistance, and materials contact:

Dale L. Johnson, Ph.D. Department of Psychology University of Houston Houston, TX 77204-5341

Or alternate address:

831 Witt Road Taos, NM 87571

E-mail: dljohnson@uh.edu

Phone: 505.758.7962 Fax: 713.743.8633

BEST PRACTICE: The Incredible Years Parent and Children Videotape Series

Description of Best Practice

(Excerpt from Strengthening America's Families: Promising Parenting Strategies for Delinquency Prevention, Office of Juvenile Justice and Delinquency Prevention, 1993, pp. 40-41.)

Program Objectives

Short-term objectives for parents are to improve communication skills with their children, improve limit-setting skills by means of nonviolent discipline techniques, improve their own problem-solving skills, and learn effective methods of anger management. For children, short-term objectives include reduction of the frequency and number of conduct problems and improvement of pro-social skills.

Program Strategies

The basic and advanced series consists of 15 videotape programs, each building on the last. Five two-hour sessions are usually required to complete the first two programs, though some groups may take longer. Most parent groups take 12-14 weeks (2 to 2 1/2 hours per week) to complete the basic series (9 videotapes). The advanced series takes an additional 6-19 sessions (6 videotapes). Groups usually range from 10 to 14 participants; one trainer is needed per group. On-site day care is recommended for those parents who cannot arrange or afford baby-sitting.

Recruitment and Retention

Families at risk for abuse or with a history of abuse or child misconduct problems may be referred by therapists or clinicians.

Staffing

While the program has been researched with extensively trained and experienced therapists, it could be used by many groups in the community who work with families (e.g., teachers, parent educators, nurses, physicians, child protective service workers, etc.) Professional backgrounds of instructors who have used the program include advanced degrees in psychology, social work and nursing. Instructor training is through self-study with the leader's manual and videotapes provided with the program. Training workshops are offered; duration has varied from one day to two weeks, depending on the background and experience of the leaders-in-training, and on the nature of the families they work with. Workshop costs vary depending on length.

Resources Needed and Materials Available

The complete program includes videotapes, an instructor's manual, and a set of manuals for the participants. The leader's guide for the parents and children series contains a brief recap of the parent/child interactions and the author's narration for each vignette, a summary of the important points, topics for discussion, and all of the necessary checklists and forms for administering the program. The leaders guide also describes how to use the parents and children series as a self-administered program or with groups. The participants' workbooks for each of the video cassettes contain all of the information needed by participants using the basic program in a self-administered format. This workbook contains all of the checklists, forms, and handouts for using the parents and children series. The complete program costs \$1,300. Individual programs cost \$175 - \$245 each.

Comments on Implementation/Replication

This program should be fairly easy to implement, due to the extensive materials available.

In 1992, three new programs (5 videotapes) were produced for school-aged children, including parent models representing over 50% of families from differing cultural backgrounds. The purposes of these programs are to promote parents' selfconfidence and competence in using positive parent management strategies in order to promote children's social skills, support their academic success, increase their self-esteem and reduce inappropriate behavior at home and at school.

A new five-part videotape program focuses on helping parents understand ways to support their children's education. It includes promoting self-confidence, fostering good learning habits, dealing with academic discouragement, parents participating in homework, and using parent-teacher conferences to advocate for your child.

New Videotapes for Children

The Dinosaur Social Skills and Problem-Solving Curriculum for Young Children is designed to promote non-aggressive ways for children to solve common conflicts, appropriate classroom behaviors, and positive social skills with other children and adults. It contains 9 videotapes, teacher manuals, letters to parents, and 40 laminated teaching materials.

Risk Factors Addressed

Family management problems Early antisocial behavior

Protective Factors Addressed

Bonding: Family

CSAP Strategy

Information dissemination Education

Type of Strategy

Universal Selective

Populations Appropriate for This Best Practice

- Parents of children aged 2-8 years
- · Parents of oppositional children aged 3-8 years
- · Parents at risk of abuse or neglect
- Teenagers taking baby-sitting classes or family life classes
- · Family therapists, social workers, child psychologists, teachers, nurses, physicians, child protective service workers, and day care providers.

Evaluating This Best Practice

This best practice comes with an evaluation tool that can be used when implementing this strategy.

Evaluation Tool Cost:

There is no cost for the evaluation tool.

The following are suggestions of areas you may want to assess if you implement this best practice:

- · Assess the increase in family management skills.
- Assess decrease in children's behavior problems and increase in their pro-social behavior.

Research Conclusions

(Excerpt from Strengthening America's Families: Promising Parenting Strategies for Delinquency Prevention, Office of Juvenile Justice and Delinquency Prevention, 1993, p. 41)

The series has been researched and field tested with over 600 families, including normal children and those with conduct problems (Webster-Stratton, 1981, 1982, 1989, 1990, 1991).

Results indicate that:

- Parents were able to significantly reduce children's behavior problems and to increase their pro-social behavior.
- Parents reported that they felt more confident and comfortable about their parenting skills after completing the course
- One to three year follow-up assessments indicate that more than two-thirds of the clinic-referred (i.e., abusive, conduct-disordered) families continued to maintain positive parent-child interactions and normal child behavior.

Costs as of December 2001 (Subject to Change)

Training Time:

3 days (21 hours) - Parent Training

2 days (14 hours) - Child Training

Training Cost:

\$1,300 per day plus travel expenses, lodging, per diem, and other expenses.

Note: There are tips for hosting a successful workshop that can be provided.

Materials Cost:

\$1,300 plus shipping for materials plus training costs: (Basic)

\$775 plus shipping and handling, plus training if not already done: (Advance)

\$995 plus shipping and handling, plus training if not already done: (School Age)

\$975 plus shipping and handling, plus training cost: (Dina Dinosaur Program for Small Group Therapy)

\$1,075 plus shipping and handling, plus training cost: (Dina Dinosaur Classroom Curriculum)

Strategy Implementation:

Cost varies

Special Considerations

The following should be taken into consideration before selecting this strategy to be implemented in your community:

· Childcare needs of parents should be considered

Contact Information

For training, materials, and more information visit web site: http://www.incredibleyears.com

or contact:

Lisa St. George, Administrative Director The Incredible Years 1411 8th Avenue West Seattle, WA 98119

E-mail: incredibleyears@seanet.com Fax and Phone: 206.285.7565 or

888.506.3562

BEST PRACTICE: Keep a Clear Mind 63

BEST PRACTICE: Keep a Clear Mind

Description of Best Practice

(Excerpt from CSAP's Model Program web site http://modelprograms.samhsa.gov)

Keep A Clear Mind (KACM) is a parent/child substance abuse prevention program for families with children in grades four through six. This home-based program developed by the University of Arkansas uses a correspondence format and consists of four weekly lessons on alcohol, tobacco, marijuana, and tools to avoid drugs. KACM's overall goal is to increase parent/child communication regarding drug prevention and to develop specific youth beliefs and skills to refuse and avoid "gateway" drug use.

The KACM program uses classroom lessons, incentives, and, in some cases, newsletters. Each of these services is described below.

Classroom Lessons

Each of the lessons provides a brief introduction to the weekly topic, followed by a sequence of five activities to be completed at home with a parent. The activities include answering simple questions about the harms of drug use and the prevalence of peer drug use, listing reasons not to use drugs, writing "no" statements to resist pro-drug use social pressures, selecting the best ways to refuse and avoid drugs from a list of alternatives, and completing contracts to refuse and avoid drugs. KACM lessons are designed to be introduced at the beginning of the week by the classroom teacher or a community agency staff member. Finished lessons are to be returned by the end of the week.

Incentives are provided for students returning completed lessons within an indicated time period. Generally, lessons go home on Monday and a sheet for parents indicating that lessons have been completed is returned on Friday. Some incentives have included tickets to sports events, bookmarks, folders, stickers, and pens.

Newsletter

Parent newsletters are sent home biweekly over a 10-week period, following the initial four lessons. Newsletters prompt parents to provide encouragement to their children and to reinforce the importance of "saying no to drugs." The newsletters also provide parents with specific tips for communication with their children.

Risk Factors Addressed

Favorable attitudes toward drug use Parental attitudes toward drug use

Protective Factors Addressed

Healthy beliefs and clear standards Skills: Social skills and refusal skills

CSAP Strategy

Education

Type of Strategy

Universal

Populations Appropriate for This Best Practice

Students in elementary school grades 4, 5, and 6 and youth in non-school settings of the same age, and their parents.

Evaluating This Best Practice

This best practice comes with an evaluation tool, available upon request, that can be used when implementing this strat-

Evaluation Tool Cost:

Data analysis and written report are negotiated on an indi-

The following are suggested areas to assess when implementing this practice:

- · Assess change in parental and youth attitudes toward drug use
- · Assess social skills and refusal skills gained by youth participants

Costs as of May 2001 (Subject to Change)

Training is not necessary to implement this program. However, training is available upon request.

Training Time: One-half day Training Cost: \$1,000 plus travel

Strategy Implementation: \$3.95 per participant

This strategy implementation cost figure includes the following: Keep A Clear Mind Lessons, parent newsletters. and incentives (bookmarks, bumper stickers, pencils, and other).

Special Considerations

None identified by program developer

Research Conclusions

(Excerpt from Journal of Drug Education, 1996, Vol. 26, Number 1, pp. 57-68.)

Students

Students in the KACM groups were more likely than students in the control group to move toward a no-use position. Similarly for two items related to peer use, students in the two KACM groups were more likely to change toward a more realistic view of the situation. Additionally, students in the KACM groups were more apt to move to a realization that tobacco does have harmful effects on young people and to perceive their parents as having a negative view of marijuana use.

Parents

When compared to parents in the control group, parents in the two KACM groups were more likely to express that their child had an increased ability to resist pressure to use the substance addressed in the KACM program, a decreased expectation that their child would try these substances, a more realistic view of their use among young people, and a greater realization of the harmful effects.

Student Perception

Two other items to show significant change were concerned with student perception of peer alcohol and tobacco use. A number of students had mistakenly thought that "most kids" use these substances on a daily basis but made a more accurate assessment of the situation after exposure to accurate information. This is an important finding in that children's expectancies regarding peer drug use is considered one of the processes influencing their own use.

Expected Use

The final two items to show change were those dealing with expected use of cigarettes and snuff. Students in the KACM

groups reported a decreased likelihood of using these substances when compared to students in the control group.

Contact Information

For more information on this program, visit web site: http://modelprograms.samhsa.gov

Also visit web site:

http://www.uark.edu/depts/hepoinfo/clear.html

For additional information, materials or a free program sample contact:

Martha Hamman University of Arkansas HPER 326A

Fayetteville, AR 72701

E-mail: mhamman@mail.uark.edu

Phone: 501.575.5639 Fax: 501.575.6401

For training inquiries contact:

Dr. Michael Young University of Arkansas HPER 326A

Fayetteville, AR 72701

E-mail: meyoung@comp.uark.edu

Phone: 501.575.5639 Fax: 501.575.6401

BEST PRACTICE: Life Skills Training Program 65

BEST PRACTICE: Life Skills Training Program

(Botvin et al)

(Excerpt from Preventing Drug Use Among Children and Adolescents: A Research-Based Guide, National Institute on Drug Abuse, 1997, pp. 21-22 with updates provided by the Life Skills program staff.)

The Life Skills Training universal classroom program is designed to address a wide range of risk and protective factors by teaching general personal and social skills in combination with drug resistance skills and normative education. The program consists of a three-year prevention curriculum intended for middle school or junior high students. It contains 15 periods during the first year, 10 booster sessions during the second, and five sessions during the third.

Three major content areas are covered by the Life Skills Training program:

- · Drug resistance skills and information
- Self-management skills
- · General social skills

Drug resistance skills and information provides material that deals directly with the social factors promoting drug use. This content area includes material designed to:

- · Increase awareness of social influences toward drug use
- Correct the misperception that everyone is using drugs and promote anti-drug norms
- Teach prevention-related information about drug abuse
- · Teach drug resistance skills

The self-management content areas provides students with skills for increasing independence, personal control and a sense of self-mastery through teaching:

- Skills for increasing self-control and self-esteem (such as self-appraisal, goal-setting, self-monitoring and self-reinforcement)
- · General problem-solving and decision making skills
- · Critical thinking skills for resisting peer and media pressures
- Adaptive coping strategies for relieving stress and anxi-

This area includes teaching:

- General problem-solving and decision making skills
- · Critical thinking skills for resisting peer and media influences
- Skills for increasing self-control and self-esteem (such as self-appraisal, goal-setting, self-monitoring, self-reinforcement)
- · Adaptive coping strategies for relieving stress and anxi-

General social skills enhance students' social competence with a variety of general skills including:

- · Effective communication
- · Overcoming shyness
- · Learning to meet new people
- · Developing healthy friendships.

These skills are taught through a combination of instruction, demonstration, feedback, reinforcement, behavioral rehearsal, and extended practice through homework assignments.

Risk Factors Addressed

Favorable attitudes toward drug use Friends who use

Protective Factors Addressed

Healthy beliefs and clear standards Skills: Social competence

CSAP Strategy

Information dissemination Education

Type of Strategy

Universal

Populations Appropriate for This Best Practice

- 6-8th grade or 7-9th grade
- Caucasian
- African American
- Hispanic/Latino

Evaluating This Best Practice

This best practice comes with an evaluation tool that can be used when implementing this strategy.

Evaluation Tool Cost:

There is no cost presently for the tool. Life Skills Training Program does not provide data analysis services.

The following are suggested areas to assess when implementing this practice:

- · Assess decreased use of alcohol, tobacco and marijuana
- · Assess change in favorable attitudes toward drug use
- Assess skills gained in area of social competence

Research Conclusions

(Excerpt from Preventing Drug Use Among Children and Adolescents: A Research-Based Guide, National Institute on Drug Abuse, 1997, page 22 with updates provided by the Life Skills program staff.)

The Life Skills Training program has been extensively studied over the past 20 years.

Results indicate that:

- Research shows that this prevention approach can produce a reduction in tobacco, alcohol and marijuana use from 59% to 87% relative to controls.
- Booster sessions can help maintain program effects.
- Long-term follow-up data from a randomized field trial involving nearly 6,000 students from 56 schools found significantly lower smoking, alcohol, and marijuana use 6 years after the initial baseline assessment.
- The prevalence of cigarette smoking, alcohol use, and marijuana use for the students who received the Life Skills Training program was 44 percent lower than for control students, and the regular (weekly) use of multiple drugs was 66 percent lower.
- Although the early research with the Life Skills Training program was conducted with white populations, several recent studies show that it is also effective with innercity minority youth.
- It also has been found effective when implemented under different scheduling formats and with different levels of project staff involvement.
- Finally, evaluation studies indicate that this prevention program works whether the program providers are adults or peer leaders.

Costs as of May 2001 (Subject to Change)

Training Time: 14 hours

Training Cost:

\$200 per person (plus \$100 for the cost for curriculum material)

Materials Cost:

\$275 for a level 1 curriculum set (1 Teacher's Manual, 30 Student Guides and a relaxation audiocassette tape)

Please view the following web site for more details on cost: http://www.lifeskillstraining.com/ordering.html

Special Considerations

Please consider the following before selecting this strategy for your community:

• The program is usually implemented in schools.

Contact Information

For more information on this program, visit web sites:

http://modelprograms.samhsa.gov http://www.lifeskillstraining.com

Also contact:

Chris Williams, Ph.D.

141 South Central Avenue, Suite 208

Hartsdale, NY 10530

E-mail: cwilliams@nhpanet.com

Phone: 914.421.2525 Fax: 914.683.6998

For training and technical assistance, contact:

Wendy Amer-Hirsch

E-mail: wamerhirsch@nhpanet.com

Phone: 914.421.2525 or

800.293.4969

Fax: 914.683.6998

To order or preview the Life Skills Training curricula, contact:

Princeton Health Press Inc.

115 Wall Street

Princeton, NJ 08540

E-mail: PHPinfo@aol.com

Phone: 800.636.3415 Fax: 609.942.3593

For a summary copy of "Blueprint" (step-by-step instructions that will help communities plan and implement youth crime and violence prevention strategies) for this program (Cost: \$15.00 per copy) contact:

Center for the Study and Prevention of Violence

Institute of Behavioral Science University of Colorado at Boulder

Campus Box 442

Boulder, CO 80309-0442 Phone: 303.492.8465

Web site: http://www.colorado.edu/cspv/blueprints

BEST PRACTICE: Meld

Description of Best Practice

(Excerpt from materials provided by Meld, December 2001.)

Meld programs bring parents with common needs together into groups that meet over two years. They learn, grow, and become friends while solving problems and creating healthy families. Volunteer group facilitators are experienced parents who are carefully selected, trained and supported by a Meld professional in each community.

Data gathered from participants shows that, even when parents are at very high risk for possible abuse or neglect, Meld makes parenting work: non-custodial fathers in the Meld for Young Dads program establish paternity, contribute financially, and spend time with their children; Hmong parents become involved in their children's schools, despite language and cultural barriers; and more young, single mothers in the Meld for Young Moms program avoid second teen pregnancies than do other teenage mothers across the country.

Meld replicates its programs in new communities by certifying agency professionals to coordinate local programs and train local volunteers. Program coordinators receive training, consultation, and materials that guide program management. Meld's network of certified professionals shares information, ideas, support, and a common belief in the essential components of the Meld program. Meld provides these sites with ongoing support and supervision while giving local efforts national visibility.

Meld offers nine programs that use the peer-led self-help model of parents learning from each other:

- 1. Meld for Young Moms: Information and support for young single moms with children from birth to age two.
- 2. Meld for Young Dads: Helping young fathers (up to age 25) understand and participate in their child's life.
- 3. Meld for New Parents: First-time parents learn about child development from birth through age 2.
- 4. Meld Special: Support for parents of children with special needs, from birth to age 3.
- 5. Meld for Growing Families: Information and support for young moms with children age 3 to 5.
- 6. Meld for Hmong Parents: Parents explore how cultural differences affect their children's integration into American life.
- 7. Meld para la Nueva Familia: For Hispanic/Latino immigrant families struggling with bilingual/bicultural issues.
- 8. Meld for African American Young Mothers: Culturally appropriate support and information for adolescent African American mothers.

9. Meld for East African Parents: Culturally specific information and support to assist the Twin Cities' East African immigrant parents.

Risk Factors Addressed

Family management problems

Protective Factors Addressed

Bonding - Family Skills - Parenting

CSAP Strategy

Education

Type of Strategy

Universal

Populations Appropriate for This Best Practice

- · Parents of preschool children
- Young single mothers and single fathers
- Hispanic parents
- · Southeast Asian parents
- African American young moms
- East African parents
- First-time adult parents
- Parents of children with special needs

Evaluating This Best Practice

This best practice comes with an evaluation tool that can be used when implementing this strategy. Each "Evaluation Manual" is designed to meet the needs of the site coordinator. The manual contains a program evaluation history, literature review for the individual program, goals, process forms and outcome forms. Evaluation Tool Cost: \$30.00.

The following are suggested areas to assess when implementing this practice:

- · Assess change in family management skills
- · Assess parents' belief in the value of corporal punishment

Research Conclusions

(Excerpt from Strengthening America's Families' web site, http://www.strengtheningfamilies.org/index.html)

Meld's success is enhanced by its careful replication processes which have moved the program into over 150 communities. Training, technical assistance and curriculum focus on quality program development and the achievement of program outcomes. A seven site study of the Meld for Young Moms program demonstrated a positive and significant shift in attitudes and beliefs toward parenting and nurturing children.

Results include:

- · More appropriate expectations of child's abilities
- Increased empathic awareness of child's needs and appropriate response
- · Reduced belief in the value of corporal punishment
- Awareness that the child does not exist to please and love the parent, rather that the parents' purpose is to respond to the needs of the child.

These attitudes are notably linked to what is known about characteristics of parent-child relationships that prevent child abuse and neglect, thus juvenile delinquency. Other Meld programs produce similar results, with evident impacts on reduction of isolation, decreased depression, and increased knowledge of child development.

Costs as of December 2001 (Subject to Change)

Training Time: Varies

The replication and certification fee is \$18,000 total for two years. This figure includes program materials, training and technical support.

A sample budget provided by Meld outlines a cost of \$57,182 for year 1 and \$66,526 for year 2. This includes budgets for staff, training, local travel, replication and certification fee, reimbursement for parent group facilitators, group expenses, telephone, printing/copying, space/utilities, and office supplies.

Special Considerations

Please consider the following before selecting this strategy for your community:

 Close contact is maintained with each site coordinator before program implementation to determine the appropriateness of the program.

Contact Information

For more information on training, visit:

Web site: http://www.meld.org

or contact:

Nancy Clutter

Meld

219 N. Second Street, Suite 200

Minneapolis, MN 55401

E-mail: nclutter@meld.org Phone: 612.332.7563 x109

Fax: 612.344.1959

For additional information, contact:

Teri Holgate

Meld

219 North Second Street, Suite 200

Minneapolis, MN 55008

E-mail: tholgate@meld.org Phone: 612.332.7563 x 111 Fax: 612.344.1959

BEST PRACTICE: Mentoring – Big Brothers/Big Sisters

Description of Best Practice

(Excerpt reprinted with permission from the Center for the Study and Prevention of Violence, Institute of Behavioral Science, Regents of the University of Colorado, http://www.colorado.edu/cspv/blueprints/model/ten_Big.httm)

Big Brothers/Big Sisters (BBBS) is a community mentoring program which matches an adult volunteer, known as a Big Brother or Big Sister, to a child, known as a Little Brother or Little Sister, with the expectation that a caring and supportive relationship will develop. Hence, the match between volunteer and child is the most important component of the intervention. Equally important, however, is the support of that match by the ongoing supervision and monitoring of the match relationship by a professional staff member. The professional staff member selects, matches, monitors, and closes the relationship with the volunteer and child, and communicates with the volunteer, parent/guardian, and the child throughout the matched relationship.

In practice, the volunteer intervention in the traditional oneto-one relationship with a child is three to five hours per week, on a weekly basis, over the course of a year or longer. The generalized activity of that relationship is related to the goals that were set initially when the match was established. These goals are identified from the extensive case manager interview held with the parent/guardian and with the child. The foremost goal usually set is to develop a relationship one that is mutually satisfying, where both parties come together freely on a regular basis. More specific goals might relate to school attendance, academic performance, relationships with other children and siblings, general hygiene, learning new skills or developing a hobby. The goals established for a specific match are developed into an individualized case plan, which is updated by the case manager as progress is made and circumstances change over time.

Generally speaking, BBBS agency staff do not tell a volunteer specifically what activities to engage in with the child during their time together, but they guide the volunteer and make suggestions of possible activities and approaches, based on the child's and volunteer's interests and needs. Consistency in the relationship over time is a higher priority than the types of activities in which they participate.

Once the match has been initially agreed upon, in the presence of the child, volunteer, and the child's parent/guardian, it is then the responsibility of the professional staff member, known as the case manager, to maintain on-going contact with all parties in the match relationship.

The Standards and Required Procedures for One-To-One Service outlines the schedule of contacts the case manager is to have with the volunteer, as well as with the parent and/ or child. There is to be more frequent contact during the early stages of the match with an initial contact within two weeks of making the match, then monthly contact throughout the rest of the year, and then contact every three months after the first year and throughout the duration of the match. The

case manager calls the volunteer and the parent after the first and second week of the relationship to determine how the relationship is developing, and may continue on a weekly basis through the first six weeks, depending on the situation. However, it eventually develops into a monthly contact with the volunteer and the parent.

At least quarterly, the case manager is in touch with the child to learn of the youth's experiences. These supervisory contacts inform the case manager how the relationship is developing and provide an opportunity to give advice and guidance around any issues the volunteer might have, as well as to encourage and support various activities. For most agencies, the on-going case manager supervision with the volunteer takes place over the phone. The case manager is to assess the match goals on an annual basis and make appropriate adjustments to the case plan.

The Standards and Required Procedures for One-To-One Service also describes the professional practice the case manager is to follow throughout the intervention process with the volunteer, parent, and child, including maintaining confidentiality and case records.

Program Content:

Service delivery is by volunteers who interact regularly with a youth in a one-to-one relationship. Agencies use a case management approach, following through on each case from initial inquiry through closure. The case manager screens applicants, makes and supervises the matches, and closes the matches when eligibility requirements are no longer met or either party decides they can no longer participate fully in the relationship.

BBBSA distinguishes itself from other mentoring programs via rigorous published standards and required procedures:

- Orientation is required for all volunteers.
- Volunteer Screening includes a written application, a background check, an extensive interview, and a home assessment; it is designed to screen out those who may inflict psychological or physical harm, lack the capacity to form a caring bond with the child, or are unlikely to honor their time commitments.
- Youth Assessment involves a written application, interviews with the child and the parent, and a home assessment. It is designed to help the caseworker learn about the child in order to make the best possible match, and also to secure parental permission.
- Matches are carefully considered and based upon the needs of the youth, abilities of volunteers, preferences of the parent, and the capacity of program staff.
- · Supervision is accomplished via an initial contact with the parent, youth, and volunteer within two weeks of the match; monthly telephone contact with the volunteer, parent and/or youth during the first year; and quarterly contact with all parties during the duration of the match.

For more information on Big Brothers/Big Sisters, visit: http://www.colorado.edu/cspv/blueprints/model/ten_Big.htm

Risk Factors Addressed

Early initiation of the problem behavior Early and persistent antisocial behavior Low commitment to school

Protective Factors Addressed

Bonding: Adults with healthy beliefs and clear standards Healthy beliefs and clear standard

CSAP Strategy

Alternatives

Type of Strategy

Selective

Populations Appropriate for This Best Practice

10-16 years old

Evaluating This Best Practice

The following is a suggestion of areas you may want to assess if you implement this best practice:

- Assess initiation of alcohol, tobacco, and other drug use by participants
- · Assess the likelihood that participants hit other children
- Assess the academic behavior, attitude, and performance of participants.
- Assess the quality of relationships between participants and their parents or guardians.

Research Conclusions

(Excerpt reprinted with permission from the Center for the Study and Prevention of Violence, Institute of Behavioral Science, Regents of the University of Colorado, http://www.colorado.edu/cspv/blueprints/model/ten_Big.htm)

An evaluation of the BBBSA program has been conducted to assess children who participated in BBBSA compared to their non-participating peers. After an eighteen month period, BBBSA youth were:

- 46% less likely than control youth to initiate drug use during the study period.
- 27% less likely to initiate alcohol use than control youth.
- almost one-third less likely than control youth to hit someone.
- better than control youth in academic behavior, attitudes, and performance.
- more likely to have higher quality relationships with their parents or guardians than control youth.
- more likely to have higher quality relationships with their peers at the end of the study period than did control youth.

Costs and Special Considerations

None identified

Contact Information

For more information on this program, contact your local Big Brothers/Big Sisters Association or the national office:

Joseph Radalet
230 North 13th Street
Philadelphia, PA 19107
E-mail: national@bbbsa.org
Phone: 215.567.7000
Fax: 215.567.0394
Web site: www.bbbsa.org

For a copy of the "Blueprint" summary for this program (step-by-step instructions that will help communities plan and implement youth crime and violence prevention strategies, Cost: \$10 per copy) contact:

Center for the Study and Prevention of Violence

Institute of Behavioral Science University of Colorado at Boulder

Campus Box 442

Boulder, CO 80309-0442 Phone: 303.492.8465

Web site: http://www.colorado.edu/cspv/blueprints

BEST PRACTICE: Multi-Component School-Linked Community Approaches

(Tobacco Specific)

Description of Best Practice

(Excerpt from Reducing Tobacco Use Among Youth: Community-Based Approaches: A Guideline for Prevention Practitioners, Center for Substance Abuse Prevention, 1997, Prevention Enhancement Protocols System Series 1, pp.16-20.)

The primary goal of this prevention approach is to discourage adolescent tobacco use by mobilizing community systems through school-based programs. Within this prevention approach, the research and practice evidence is divided into three clusters each with its own emphasis: parent involvement, student antitobacco activism, and media interventions.

CLUSTER 1: Parent Involvement

Research demonstrates that multi-component programs are more effective than single-component interventions for preventing tobacco use among adolescents. Adding parental involvement to a school-based prevention program should therefore increase the effectiveness of the school-based program.

Activities

- · Parent surveys
- · Take-home quizzes for parents and students
- · Letters to parents
- · Smoking cessation services and self-help materials for parents
- Television segments on smoking prevention and cessa-
- Pamphlets for parents containing information about teen tobacco problems
- Educational materials for parents with tips on how to encourage their kids not to smoke
- Parent training
- · Community organizing to develop school policies discouraging tobacco use and to institute drug prevention curricula
- · Community organizing to promote community change regarding use of alcohol, tobacco, and illicit drugs by adolescents
- Media campaign to support other programs components

CLUSTER 2: Student Antitobacco Activism

Research demonstrates that multi-component programs are more effective than single-component interventions in preventing tobacco use among adolescents. Adding student antitobacco activism as a component to a school-based prevention program should, therefore, increase the effectiveness of the school-based program. Student antitobacco activism is defined as participation in planned and structured activities designed to raise awareness, provide education, or prompt social changes relating to tobacco use among youth.

- · Writing letters to: members of a favorite sports team, asking them not to use or endorse tobacco products; a restaurant manager or owner, advocating smoke-free restaurants; film producers and magazine editors protesting tobacco advertising
- · Holding poster contests
- · Creating antitobacco art projects
- · Making floats and participating in community parades and festivals
- · Writing and singing antitobacco songs
- · Revising school policies regarding tobacco use
- · Planning and attending a culturally specific youth health
- Designing and painting an antitobacco mural at a junior high school
- · Participating in the production of antitobacco animated videos, in debates regarding tobacco issues, and in the development of a smoking education curriculum

CLUSTER 3: Media Interventions

Research demonstrates that multi-component programs are more effective than single-component interventions in preventing tobacco use among adolescents. Adding mediabased interventions to a school-based prevention program should therefore increase the effectiveness of the schoolbased program.

Activities

- · Mass-media events such as press conferences, interviews, talk shows, and articles
- · Daily 5-minute television segments featuring smoking prevention that are coordinated with school curricula
- Curricula and other written information on the hazards of tobacco use for students, teachers, and parents
- · Mass-media antitobacco advertisements and public service announcements

Risk Factors Addressed

Community laws and norms favorable toward drug use Favorable attitudes toward drug use Parental attitudes favorable toward drug use

Protective Factors Addressed

Healthy beliefs and clear standards

CSAP Strategy

Information dissemination Education Community-based process

Type of Strategy

Universal

Populations Appropriate for This Best Practice

No specific populations

Evaluating This Best Practice

The following are suggested areas to assess when implementing this practice:

- Assess change in adolescents' attitudes and beliefs regarding tobacco
- · Assess changes in adolescent tobacco use rate

Research Conclusions

(Excerpt from Reducing Tobacco Use Among Youth: Community-Based Approaches: A Guideline for Prevention Practitioners, Center for Substance Abuse Prevention, 1997, Prevention Enhancement Protocols System Series 1, pp. 16-20.)

Level of Evidence CLUSTER 1

The research and practice evidence reviewed indicates that it is possible to implement multi-component prevention programs that combine parental involvement components with other prevention efforts, such as school-based programs:

- There is medium evidence that multi-component, school-linked programs with a parental component promote (1) improved parental knowledge about adolescent tobacco use, (2) the development of negative attitudes by parents toward tobacco use, and (3) the mobilization of parents to speak with their children about not using tobacco.
- There is medium evidence that these programs change students' perceptions regarding tobacco use.

CLUSTER 2

The research and practice evidence reviewed indicates that it is possible to implement prevention programs that involve student activism:

- There is medium evidence that adolescents can be mobilized to participate in antitobacco activism within schools and the community.
- There is medium evidence that student activism is effective in improving adolescents' knowledge about tobacco and in promoting negative attitudes regarding tobacco use.
- There is suggestive but insufficient evidence that student activism is effective in preventing adolescent tobacco use because few studies have assessed this outcome.

CLUSTER 3

The research evidence reviewed indicates that it is possible to develop adolescent tobacco use prevention programs utilizing media components in combination with other prevention efforts (such as school-based programs):

- There is medium evidence that exposure to media-based antitobacco interventions, in concert with school-based tobacco education, can change adolescent students' knowledge, attitudes, and beliefs about tobacco use and industry marketing practices.
- There is medium evidence that multi-component prevention programs that include media-based interventions are effective in preventing adolescent tobacco use.

Lessons Learned From Reviewed Evidence

- Programs designed to enhance the effectiveness of schoolbased curricula result in increased family and student attention to antitobacco messages. However, there is limited evidence that these programs reduce tobacco use among youth.
- The effects of a fully implemented school- and community-based intervention (including parental involvement) to reduce adolescent tobacco use as part of a broader substance abuse prevention strategy may be limited by the community's view of tobacco use as a minor issue in relation to other forms of substance abuse and the likelihood that addressing adolescent tobacco use will not be considered a priority.
- The effectiveness of multi-component prevention programs may be related to the multiplicative effect, that is, the net effect of a program may be greater than the sum of the individual effects of the program components. In other words, the ways in which program components interact with each other and their effects on each other are largely unknown. As a result, it may not be feasible to assess the independent contributions of each component.
- Students who voluntarily participate in school-based antitobacco activism projects may not be at high risk for using tobacco. The program, therefore, may be focused disproportionately on those who are already at low risk.

Costs and Special Considerations

None identified

Contact Information

For more information on this best practice, order a free copy of the following publications from SAMHSA's National Clearinghouse for Alcohol and Drug Information (NCADI) at:

Phone: 800.729.6686, or Web site: http://ncadi.samhsa.gov

Reducing Tobacco Use Among Youth: Community-Based Approaches, Center for Substance Abuse Prevention, 1997, Prevention Enhancement Protocol System Series 1, publication order no. "PHD 745" (Prevention Practitioners Guide) and "PHD 746" (full document).

BEST PRACTICE: Multisystemic Therapy Program

Description of Best Practice

(Excerpt from Strengthening America's Families' web site: http://www.strengtheningfamilies.org/index.html)

Multisystemic therapy (MST) is an intensive family-based treatment that addresses the known determinants of serious antisocial behavior in adolescents and their families. As such, MST treats those factors in the youth's environment that are contributing to his or her behavior problems. Such factors might pertain to individual characteristics of the youth (e.g., poor problem-solving skills), family relations (e.g., inept discipline), peer relations (e.g., association with deviant peers), and school performance (e.g., academic difficulties). On a highly individualized basis, treatment goals are developed in collaboration with the family, and family strengths are used as levers for therapeutic change. Specific interventions used in MST are based on the best of the empirically validated treatment approaches such as cognitive behavior therapy and the pragmatic family therapies. The primary goals of MST are to reduce rates of antisocial behavior in the adolescent, reduce out-of-home placements, and empower families to resolve future difficulties.

Several programmatic features are crucial to the success of MST:

- The use of a home-based model of service delivery (i.e., low caseloads, time limited duration of treatment) removes barriers of access to care and provides the high level of intensity needed to successfully treat youths presenting serious clinical problems and their multi-need families.
- Second, the philosophy of MST holds service providers accountable for engaging the family in treatment and for removing barriers to successful outcomes. Such accountability clearly promotes retention in treatment and attainment of the treatment goals.
- Third, outcomes are evaluated continuously, and the overriding goal of supervision is to facilitate the clinicians' attempts to attain favorable outcomes.
- Fourth, MST programs place great emphasis on maintaining treatment integrity, and as such, considerable resources are devoted to therapist training, ongoing clinical consultation, service system consultation, and other types of quality assurance.

Note: Some funding agencies may classify this as an "intervention" or "treatment" program and may, consequently, not fund it with prevention dollars.

Risk Factors Addressed

Family management problems Antisocial behavior

Protective Factors addressed

Bonding – Family Skills

CSAP Strategy

Education

Type of Strategy

Indicated

Populations Appropriate for This Best Practice

- Chronic, violent, or substance abusing juvenile offenders at high risk of out-of-home placement and their families
- · 10-18 years old

Evaluating This Best Practice

This best practice comes with an evaluation tool that can be used when implementing this strategy. It is a fidelity measure that has been shown to be predictive of long-term outcomes.

Evaluation Tool Cost: No cost.

The following are suggestions of areas you may want to assess if you implement this best practice.

- · Assess change in family management skills
- Assess rate of criminal activity and incarceration of youth participants
- Assess rate of out-of-home placements of youth participants
- Assess mental health problems for youth participants

Research Conclusions

(Excerpt from MST's' web site, http://www.mstservices.com/text/treatment.html)

Evaluations of MST have demonstrated:

- Reduced long-term rates of criminal offending in serious juvenile offenders
- Reduced rates of out-of-home placements for serious juvenile offenders
- · Extensive improvements in family functioning
- Decreased mental health problems for serious juvenile offenders
- Favorable outcomes at cost savings in comparison with usual mental health and juvenile justice services

Cost as of December 2001 (Subject to Change)

Training Time:

Program support and training in MST is provided on-site by MST Services, Inc. using essentially the same protocol that has been used in successful clinical trials of MST with violent and chronic juvenile offenders. Prior to receiving training, program development and start-up technical assistance on-site meetings are held. Therapists and supervisors receive training in MST in three ways. First, five days of intensive on-site orientation training are provided. Second, 1.5-day "booster" sessions occur on-site on a quarterly basis. Third, treatment teams and their supervisors receive weekly telephone consultation from MST experts.

Training Cost:

In addition to the elements of clinical training, the package of program support and training services includes a pretraining site assessment, assistance with program specification and design (including the development of quality control and outcome tracking system) and ongoing assistance with overcoming barriers to achieving successful clinical outcomes. The cost of program support and training is based on an all-inclusive annual per team fee. Fees range from \$15,000 to \$24,000 per team, plus travel expenses based upon the nature and size of the program. Also, an annual \$5,000 license fee is required, regardless of the number of teams, and each individual within that organization using MST (therapists and supervisors only) pay an annual license fee of \$200 per person.

Staff training in MST is an on-going process. A primary objective of MST Services is to assist organizations in building capacity to provide for part or all of their MST program's long-term training needs. In this context, program support and training expenses should be viewed as the annual cost of a Quality Assurance (QA) program. Based upon an average annual service capacity of 15 families per therapist per year, the total long-term QA costs (program support and training) is usually in the range of \$400 to \$550 per youth served.

Implementation Cost:

Multisystemic Therapy (MST) is conducted by therapists who are part of a MST "team." Two to four MST therapists and their on-site supervisor make up a MST team which works together for purposes of group and peer supervision, and to support the 24 hour/7 day/week on-call needs of the team's client families. MST therapists are full-time master's-level or highly clinically-skilled bachelor's-level

mental health professionals. MST supervisors are typically assigned to the program a minimum of 50% time and may carry a small caseload if assigned full-time. MST supervisors are either doctoral-level or highly competent Master's-level professionals.

MST staff must be highly accessible to their clients and often have both pagers and cellular phones. Typically MST programs budget for mileage reimbursement to cover 8,000 to 12,000 miles a year per therapist. Internet access for administrative staff is required for scoring of required Quality Control measures. It is recommended that a small amount of flexible funds be available to the MST team (\$100 per client family) for occasional and/or emergency needs. An annual program-licensing fee is required and is based upon the size of the MST program.

Special Considerations

The following should be taken into consideration before selecting this strategy to be implemented in your community:

- MST Services conducts a site assessment process to assure that MST is a good fit for your needs.
- Complete the "Go, No-Go" questionnaire on MST's web site (http://www.mstservices.com/text/go_nogo.htm) to assist in determining how ready your organization is to proceed with an MST implementation.

Contact Information

For more information on MST visit web site:

http://www.mstservices.com

For information on training and technical assistance, contact:

Marshall E. Swenson, MSW, MBA Manager of Program Development, MST Services Post Office Box 21269 Charleston, SC 29413-1269

E-mail: ms@mstservices.com Phone: 843.856.8226 x14 Fax: 843.856.8227

BEST PRACTICE: NICASA Parent Project 75

BEST PRACTICE: NICASA Parent Project

Description of Best Practice

(Excerpt from Strengthening America's Families' web site, http://www.strengtheningfamilies.org/index.html)

The Parent Project was designed specifically to meet the needs of working parents in the workplace environment to address issues of effective parenting.

The goals of the program are to enrich family relationships and promote healthy environments that build resistance to social and personal dysfunction. Specifically, it focuses on the need to:

- · Establish supportive networks among working parents
- · Improve parent/child relationships
- · Increase ability to balance work and family life
- Improve corporate climate for workers
- Improve parent skills in preventing and identifying substance abuse problems in themselves and their children

The Parent Project includes programs for parents with children of the following ages: birth to 4 years old, elementary school age, and adolescents.

The program has also been modified and piloted at three work sites to address specific issues related to single working parents. The program is presented at lunch time at a worksite.

At each developmental level, the program addresses issues common to all parents such as:

- · Balancing work and family
- Communication
- · Discipline
- Learning styles
- Sibling relationships
- · Sex role conditioning
- Substance abuse and others

The program also focuses on specific developmental stage issues such as:

- Child care
- **Tantrums**
- Sleeping and eating patterns
- Communicating with school personnel
- · Peer pressure and establishing family substance use policies for elementary school children
- School performance
- Male/female relationships and increasing levels of responsibility for adolescents

Risk Factors Addressed

Family management problems Favorable parental attitudes toward drug use

Protective Factors Addressed

Skills - Parenting

CSAP Strategy

Education

Type of Strategy

Universal

Populations Appropriate for This Best Practice

- · Parents of children ages birth to 4
- Parents of children in elementary school
- · Parents of adolescent children
- · Single working parents

Evaluating This Best Practice

This best practice comes with an evaluation tool that can be used when implementing this strategy.

Evaluation Tool Cost:

There is no additional cost for the evaluation tool which is provided at the trainings.

The following are suggested areas to assess when implementing this practice:

- · Assess change in family management skills
- · Assess change in parents' negative attitudes toward drugs
- · Assess change in negative child behaviors

Research Conclusions

(Excerpt from Strengthening America's Families' web site, http://www.strengtheningfamilies.org/index.html)

- · In a longitudinal study of 191 parents using a quasi-experimental design, parents in a high dosage group reported significant and enduring changes in child behaviors, and rated child behavior more positively.
- Parenting practices and knowledge changed significantly in the desired direction, parental punitiveness and irritability declined, and parental stress and depression were reduced.
- There were positive increases in substance abuse knowledge and negative attitudes toward drugs, for parents who received high dosage levels of the program.

Costs as of May 2001 (Subject to Change)

Training Time: Two and one-half days

Training Cost:

• \$3,000 per trainer

- \$155 per person for two manuals and extra materials
- · Extra costs such as shipping, lodging, meals, travel

Note: The training includes information regarding marketing, philosophy, working with corporate culture, cultural adaptations for community programs, reaching diverse populations, and working with the parents' situation (long hours etc.). Much of the training is experiential.

Special Considerations

Please consider the following before selecting this strategy for your community:

- The program is conducted in the community workplace on the lunch hour
- The handouts are for high school graduates

Contact Information

For more information, training, and/or technical assistance, contact:

Joyce Millman, MA

Northern Illinois Council on Alcoholism and Substance

Abuse (NICASA)

31979 North Fish Lake Road

Round Lake, IL 60073

E-mail: joycemil@attbi.com or

jmillman@nicasa.org

Phone: 847.546.6450, Ext. 232

Fax: 847.546.6760

BEST PRACTICE: Norms for Behavior and Rule Setting in School

(Gottfredson)

Description of Best Practice

"Norms for Behavior and Rule Setting in Schools" is a type of strategy that has been used in several different programs/ projects. This strategy has been tested and shown effective in the following projects. Please review these programs to see how to implement this strategy: Project PATHE, Project CARE, and Project BASIS.

(Excerpt from Preventing Crime: What Works, What Doesn't and What's Promising, Office of Justice Programs' Research Report, by University of Maryland, Department of Criminology and Criminal Justice, 1997, pp. 5-15.)

Program components necessary for effective implementa-

- · Increasing clarity of rules and consistency of rule enforcement through revisions to school rules and computerized behavior tracking system
- · Improving classroom organization and management through teacher training
- Increasing the frequency of communication with the home regarding student behavior through systems to identify good student behavior and a computerized system to generate letters to parents regarding both positive and negative behavior
- Replacing punitive disciplinary strategies with positive reinforcement of appropriate behavior through a variety of school and classroom level positive reinforcement strategies

Risk Factors Addressed

Lack of commitment to school Community laws and norms favorable toward drug use

Protective Factors Addressed

Healthy beliefs and clear standards

CSAP Strategy

Environmental

Type of Strategy

Universal

Populations Appropriate for This Best Practice

Elementary and middle schools

Evaluating This Best Practice

The following are suggested areas to assess when implementing this practice:

- Assess pre and post incidences of targeted behavior, i.e. bullying, vandalism, drug use
- · Assess pre and post incidences of disciplinary action for problem behavior
- · Assess pre and post teacher reporting of classroom dis-
- · Assess decrease in delinquent behavior

Research Conclusions

(Excerpt from Preventing Crime: What Works, What Doesn't and What's Promising, Office of Justice Programs' Research Report, by University of Maryland, Department of Criminology and Criminal Justice, 1997, pp. 5-16.)

Programs aimed at setting norms or expectations for behavior, either by establishing and enforcing rules or by communicating and reinforcing norms in other ways, have been demonstrated in several studies of reasonable methodological rigor to reduce alcohol and marijuana use and to reduce delinquency. Note, however that schools where rules were manipulated also used school teams to plan and implement the programs, so it is not possible to separate the specific effects of school rules and discipline strategies from the more general effects of encouraging teams of school personnel to solve their schools' problems.

Costs and Special Considerations

Not applicable

Contact Information

To implement this strategy, review the following programs/ projects: Project PATHE, Project CARE, Project BASIS.

BEST PRACTICE: Nurse Family Partnership

(Formerly Prenatal/Early Infancy Project)

Description of Best Practice

(Excerpted with permission from: Developmental Research and Programs. *Communities That Care Prevention Strategies: A Research Guide to What Works*, 1996, pp. 11-12.)

The Prenatal/Early Infancy Project was a comprehensive research project targeting young, unmarried mothers in a semi-rural Appalachian region of New York that had high rates of poverty and child abuse. The project included multiple interventions, such as home visitations by a nurse from pregnancy through age two, health education for parents, job and educational counseling, parent training, and social service linkages through referral and advocacy systems. Home visitors encouraged close friends and family members to participate in the home visits, and to help mothers with child care and household responsibilities.

The prenatal and infant health care component of the program involved screening and referral, home visits every two weeks during pregnancy, free transportation to well-child care clinics, and continued nurse visitation until the children were two years old. Registered nurses, who had participated in a three-month training program, worked in two-person teams to deliver the program.

(Citation listed in CTC publication: Olds, D.L., C.R. Henderson, Jr., R.L. Tatelbaum, MD. & R. Chamberlain, MD. Improving the Delivery of Prenatal Care and Outcomes of Pregnancy: A Randomized Trial of Nurse Home Visitation. Pediatrics (January, 1986) vol. 77 No. 1.)

(Citation for 15-year follow-up study: Olds DL, Eckenrode J, Henderson CR, Kitzman H, Powers J, Cole R, Sidora K, Morris P, Pettitt LM, & Luckey D. Long-term Effects of Home Visitation on Maternal Life Course and Child Abuse and Neglect: A Fifteen-Year Follow-up of a Randomized Trial. Journal of the American Medical Association. (August 27, 1997) Vol. 278, No. 8. 637-643.)

Risk Factors Addressed

Extreme economic deprivation
Favorable parental attitudes toward the problem behavior
Family management problems
Constitutional factors

Protective Factors Addressed

Healthy beliefs and clear standards Bonding: Opportunities, skills and recognition

CSAP Strategy

Information dissemination Problem identification and referral Community-based process

Type of Strategy

Selective

Populations Appropriate for This Best Practice

- Rural
- Semi-rural

Evaluating This Best Practice

This best practice comes with an evaluation tool that can be used when implementing this strategy.

Evaluation Tool Cost:

\$1,000 initial installation of system, plus \$5,200 per year fee for services. This figure includes:

Initial installation of Clinical Information Software, technical assistance and trouble shooting of software and data collection problems, monthly data summary reports, guidance on self-generated reports, and annual comprehensive summary reports.

The following are suggested areas to assess when implementing this practice:

- Assess rate of child abuse and neglect for project participants compared with a non-participating group of individuals
- · Assess graduation rate of participants
- Assess employment rate of participants out-of-school
- Assess whether number of subsequent pregnancies is reduced

Research Conclusions

This comprehensive program produced significant reductions in the following risk factors:

- Teen mothers and smoking mothers had fewer prenatal difficulties
- Two years after the program ended, the rate of child abuse and neglect was 4% for project participants compared with 19% for non-participating controls
- Program participants were twice as likely as controls to graduate from high school
- Older participating mothers were more likely to be employed
- Subsequent pregnancies were delayed (Olds et al., 1986; Olds and Kitzman, 1993).

A follow-up study showed that this program of prenatal and early childhood home visitation by nurses reduced the number of subsequent pregnancies, the use of welfare, child abuse and neglect, and criminal behavior on the part of low-income, unmarried mothers for up to 15 years after the birth of the first child.

Costs as of December 2001 (Subject to Change)

Training Time:

11 days total (three separate training sessions) (roughly 80 hours)

Training Cost:

Varies depending upon group size, etc. Consult with contact prior to budgeting. Approximately \$2,000 per person plus travel/food/lodging.

Note: Training is required. It is a three-part series:

- Training is from the National Center for Children, Families and Communities at the University of Colorado
 Health Sciences Center, plus training from NCAST
 through the University of Washington School of Nursing.
- The first week is in Denver and covers the theory behind the program model, the Clinical Information System and the pregnancy phase of the program.
- Trainings two and three are done regionally and cover the infancy and toddler guidelines, respectively.

Strategy Implementation:

Variable - approximately \$250,000/year for 100 participants.

Special Considerations

Please consider the following before selecting this strategy for your community:

- Implementation of this program is done after a series of conversations with the National Center for Children, Families and Communities and the prospective site.
- Interested parties should contact the National Center (Matt Buhr-Vogl) as early as possible if considering this approach.
- · Home Visit Guidelines necessary for program implemen-

tation are only available to sites under contract with the National Center and who are sending nurse home visitors/supervisors through our training process.

Additionally:

- Is there community support to implement the program?
- Does the community have at least 100 first-time low-income mothers who would benefit from enrolling in the program over a one-year period, and does the implementing agency have experience reaching and working with this population?
- Does the operating agency see this program as critical to achieving its mission?
- Is there sustainable financing?

Note: These and many other questions are addressed by their site development/community planning process, for which there is significant technical assistance available.

Contact Information

Note: Materials are available for approved sites only.

For training, technical assistance, additional program information contact:

Matt Buhr-Vogl, MPH Nurse-Family Partnership National Center for Children, Families and Communities 4200 E. 9th Ave., Box C288-13

Denver, CO 80262

E-mail: matt.buhr-vogl@uchsc.edu

Phone: 303.315.0896 Fax: 303.315.1489

Web site: http://www.nccfc.org

BEST PRACTICE: The Nurturing Program

Description of Best Practice

(Excerpt from the Nurturing Parenting Program in December 2001.)

The Nurturing Parenting Programs are validated, family-centered programs designed to build nurturing skills as alternatives to abusive parenting and child rearing attitudes and practices. The ultimate outcomes are to stop the generational cycle of child abuse by building nurturing parenting skills, reduce the rate of recidivism, reduce the rate of juvenile delinquency and alcohol abuse, and lower the rate of multi-para teenage pregnancies.

The Nurturing Programs address parents' needs for nurturance and re-parenting and also provide concurrent nurturing learning experiences for children. Parents and children are taught similar skills and attitudes to maximize learning and maintenance of new knowledge. Based on a re-parenting philosophy, parents and children attend separate groups that meet concurrently with cognitive and affective activities designed to build self-awareness, positive self-concept/self-esteem and empathy, to teach alternatives to yelling and hitting, enhance family communication and awareness of needs, replace abusive behavior with nurturing, promote healthy physical and emotional development and teach appropriate role and developmental expectations.

The Nurturing Parenting Programs have been field tested with families at risk for abuse and neglect, families identified by local social services as abusive or neglectful, families in recovery for alcohol and other drug abuse, families at risk for delinquency, parents incarcerated for crimes against society, and adults seeking to become adoptive or foster parents. As such, a primary use of the Nurturing Parenting Programs is to treat child and adolescent maltreatment, prevent its recurrence, and build nurturing parenting skills in at-risk populations.

There are 13 separate Nurturing Parenting Programs currently available:

- · Prenatal Families
- · Parents and Their Infants, Toddlers, and Preschoolers
- · Parents and Their School-Age Children
- · Parents and Adolescents
- · Teenage Parents and Their Families
- Foster and Adoptive Parents and Their Children
- Parents with Special Learning Needs and Their Children
- Families in Substance Abuse Treatment and Recovery
- · Hmong Parents and Their Adolescents
- African American Families
- Crianza con Carino programa Para Padres y Ninos (Hispanic Patents and Their Children, Birth to 5 years)
- Crianza con Carino programa Para padres e Hijos (Hispanic Parents and Their Children, 4 to 12 years)
- The ABC's Parenting Program for Parents and Children

Risk Factors Addressed

Family management problems Family conflict

Protective Factors Addressed

Bonding: Family Skills

CSAP Strategy

Information dissemination Education

Type of Strategy

Selective

Populations Appropriate for This Best Practice

Families whose children are at high risk for:

- Alcohol and drug use because of a family history of alcohol and drug abuse
- Parental communication problems
- · Family management problems, or youth problems
- African American, Asian/Pacific Islanders, Caucasian, Hispanic/Latino, Hmong

Evaluating This Best Practice

This best practice comes with an evaluation tool that can be used when implementing this strategy.

Evaluation Tool Cost:

Please visit http://www.nurturingparenting.com/aapi/index.htm for evaluation tool cost information.

The following are suggested areas to assess when implementing this practice:

- Assess improvements in family management skills
- · Assess improvements in family cohesion

Research Conclusions

(Excerpt from Strengthening America's Families: Promising Parenting Strategies for Delinquency Prevention, Office of Juvenile Justice and Delinquency Prevention, 1993, p. 57.)

These programs have been field tested nation-wide; results of such trials are included in program materials. Nurturing Programs use the Adult-Adolescent Parenting Inventory (AAPI) as a pre/post test to measure parenting attitudes.

Costs as of December 2001 (Subject to Change)

Training Time:

2-3 days, depending on the group's level of sophistication

Training Cost:

Costs vary depending on whether the workshops are sponsored by an agency seeking to implement the Nurturing Program or whether the training is provided by the community and participants register individually. In the latter case, registration fees generally average \$125 per workshop.

Implementation Cost:

 One-time purchase of complete program, which includes manuals, videos, instructional aids, and assessment inventories, ranges from \$875 to \$1800 depending on the program purchased.

- Snacks: Weekly snacks for group programs at \$20-\$40 per session
- · Staff time to facilitate the program
- Transportation (optional): Pick-up and drop-off of fami-
- · Materials: Approximately \$300 for each complete Nurturing Program in useables (paper, crayons, etc.)

For more details on cost, visit web site: http://www.familydev.com/nurturing_programs.htm

Special Considerations

Please consider the following before selecting this strategy for your community:

- Assessment/evaluation tools are available which assist facilitators in gathering important information about parents when preparing to implement a class.
- · Facilitators need to know if parents have any learning disabilities, past history of abuse, or issues of alcohol and drug abuse that would impact the program.
- · If parents cannot read, then they would need to participate in the program for Parents with Special Learning

Needs Program, instead of the program for parents and children 5-11 years.

- · Implementing the program in the community may require special considerations to help people attend the program.
- Working with community leaders, providing transportation, food, child care, and medical care should be considered when setting up groups in the community.
- Professionals and paraprofessionals with training in teaching parents nurturing skills or a professional background in parent education are candidates to facilitate Nurturing Parenting Program classes. Empathy, positive self-worth, dependability, and sharing are desirable facilitator characteristics.

Contact Information

For training, consulting, materials and technical assistance, visit:

Web site: http://www.nurturingparenting.com

or contact:

Robert Schramm Family Development Resources 3070 Rasmussen Rd, Suite 109 PO Box 982350 Park City, UT 98098

E-mail: fdr@nurturingparenting.com

800.688.5822 Phone: Fax: 435.649.9599

BEST PRACTICE: Parent and Family Skills Training

(General)

Description of Best Practice

(Excerpt from *Family Centered Approaches*, Center for Substance Abuse Prevention, 1998, Prevention Evaluation Protocols System, pp. 9-13.)

Family functioning, structure, and values have a significant impact on children's capacity to develop pro-social skills and cope with life's challenges. Parent and family skills training can provide parents and family members with new skills. These skills enable families to better nurture and protect their children, help children develop pro-social behaviors, and train families to deal with particularly challenging children.

This prevention approach addresses two clusters based on the risk levels of the target populations:

- Families with children who are not known to have risk factors and families with children who are exposed to risk factors and are therefore at above-average risk. Common risks might include being in a single-parent family, a family in economic distress, or a family of divorce. [Universal or selective populations.]
- 2. Families with children who are at high risk because they are exposed to multiple risk factors or have a high level of exposure to a single risk factor. Examples might be children identified as having serious behavior problems, as being delinquent, as having substance-abusing parents, or as being victims of child abuse. [Indicated population.]

Because the activities and levels of evidence are unique to each cluster, they are presented separately below. The lessons learned and recommendations for practice that follow apply to both clusters.

CLUSTER 1

This cluster, as noted above, includes families with children who have no known risk factors. As noted earlier, according to the IOM's classification system, universal preventive measures are appropriate for these families. Cluster 1 also includes families with children who are exposed to risk factors and are therefore at above-average risk. Selective preventive measures are appropriate for these families.

The parent and family training activities or interventions in this cluster include some training sessions that involve the child and other family members and others that are parent oriented. All of the activities focus on changes in:

- Parents Acquiring or improving parenting skills, child management abilities, psychological helping skills, relationship development, and empathy
- 2. Families Improving family cohesion, organization, relationships, and conflict resolution
- Youth Improving general child behavior, psychological adjustments, attachment to family, and commitment to school

Activities

- Didactic presentations, both live and videotaped, followed by discussions
- 2. Role-playing and skills practice sessions
- 3. Curriculum-based training to recognize and modify risk and protective factors
- Modeling sessions on interaction, communication, and crisis handling
- 5. Cognitive-behavioral workshops and multi-session training programs

CLUSTER 2

As noted above, this cluster includes families with children at high risk for substance abuse because they are exposed to multiple risks or have a high level of exposure to a single factor, such as conduct disorder. Indicated preventive measures are appropriate for these families (Institute of Medicine 1994).

The parent and family training activities or interventions examined in this cluster include parent training without child involvement, parent training with separate child training, family skills training, and parent training plus family skills training.

All of the activities focus on changes in:

- Parents Improving parents' attitudes toward their children, acquiring or improving parenting skills, child management abilities, problem-solving skills, communication skills, and crisis management abilities
- 2. Youth Improving general behavior, acquiring or improving self-control and compliance, reducing antisocial and other problem behaviors, and reducing arrest rates

Activities

- 1. Videotaped modeling sessions, with and without counseling and practice
- 2. Manual-based training, with and without discussions
- 3. Didactic, role-playing, and skill practice sessions
- 4. Cognitive-behavioral and problem-solving skills training
- 5. Behavioral parent training
- 6. Parent and teacher training
- Structural family therapy and family effectiveness training
- 8. Parent counseling
- 9. Individual and group therapy for parents, both with and without children

Risk Factors Addressed

Parental attitudes and involvement in drug abuse Family management problems Family conflict

Protective Factors Addressed

Skills

Bonding: Family

CSAP Strategy

Education

Information dissemination

Type of Strategy

Universal, Selective, or Indicated

Populations Appropriate for This Best Practice

Not defined

Evaluating This Best Practice

The following are suggested areas to assess when implementing this practice:

- · Assess the level of communication between parent-child
- Assess family management skills
- · Assess level of family conflict
- · Assess level of family bonding

Research Conclusions

(Excerpt from *Family Centered Approaches*, Center for Substance Abuse Prevention, 1998, Prevention Evaluation Protocol System, p. 12.)

CLUSTER 1

For families with children who are not known to have risk factors and for families with children who are exposed to risk factors, the research and practice evidence reviewed indicates that it is possible to implement parent and family skills training interventions:

- There is strong evidence that these interventions can stabilize or improve the conditions that decrease risk factors for substance abuse, such as poor parent-child communication, child problem behavior, inadequate parenting skills, poor family relationships, parental substance use, family conflict, and family disorganization.
- There is suggestive but insufficient evidence that, when specifically directed, these interventions can improve children's social skills and pro-social behavior.

- There is suggestive but insufficient evidence that, when specifically directed, these interventions can reduce parental stress and depression, improve children's self-esteem, promote improvements related to differences in social assimilation between parents and children.
- There is suggestive but insufficient evidence that using a combination of parent training, children's social skills training, and family relationship training leads to greater improvements overall in parent-child relationships than would any of these interventions alone.

CLUSTER 2

For families with children who are at high risk for substance abuse because they either are exposed to multiple risk factors or have a high-level exposure to a single risk factor, such as conduct disorder, the research and practice evidence indicated that it is possible to implement parent and family training interventions:

- There is strong evidence that these interventions can decrease risk factors such as child problem behavior and poor parenting skills and increase protective factors such as healthy family communication, bonding, and conflict resolution.
- There is suggestive but insufficient evidence that these interventions reduce parents' stress, depression, and substance use; improve children's self-esteem; and promote improvements related to differences in social assimilation between parents and children.
- There is strong evidence that these interventions have a
 positive and lasting effect in improving parenting skills
 and behaviors as well as reducing diagnosed problem
 behaviors in children.

Note: The criteria used to rate the strength of evidence for each prevention approach are shown in Appendix A (of the source document).

Costs and Special Considerations

Not available

Contact Information

For more information, order a copy of CSAP's Family Centered Approaches from:

National Technical Information Systems

Phone: 800.553.6847

Practitioners guide cost: \$29.50, order #PB 98159692 Reference guide cost: \$58.00, order #PB 99101800

BEST PRACTICE: Parenting (Adolescents) Wisely

Description of Best Practice

(Excerpt from Strengthening America's Families' web site http://www.strengtheningfamilies.org/index.html and from Dr. Gordon)

Parenting Adolescents Wisely (PAW) is an interactive CD-ROM based program designed for families at-risk with children from early elementary to high school age. Video programs which overcome illiteracy barriers meet the needs of families who don't usually attend or finish parenting education. PAW seeks to help families enhance relationships and decrease conflict through behavior management and support. It enhances child adjustment and potentially reduces delinquency, substance abuse, and involvement with the juvenile justice system. In addition, PAW builds parental confidence in parenting skills. It seeks to improve communication, problem solving, and parent-school communication, while improving school attendance and grades and reducing disciplinary infractions.

Through a self-administered, self-paced CD-ROM program, parents view video scenes of common family problems. For each problem, parents choose a solution, see it enacted and listen to a critique.

The video program covers:

- · communication skills
- problem solving skills
- · speaking respectfully
- · assertive discipline
- reinforcement
- chore compliance
- · homework compliance
- supervising children who are hanging out with peers who are a bad influence
- step-family problems
- single parent issues
- · violence, and others

The program is designed to be used by parents totally unfamiliar with computers, as well as those with computer experience. The program takes only one to two sessions lasting approximately three hours. Parents prefer using the program with their teens and pre-teens. Used as a family intervention, parents and children converse enthusiastically and learn the same skills together.

One staff member can deliver the program, which simply entails turning on the computer, booting the CD-ROM, and showing the parent(s) or parent and child how to move the mouse cursor on the screen. This procedure takes approximately two minutes and requires no skill, credentials, or training on the part of the staff member. Monitoring by the program developer is not necessary, but free telephone consultation is provided if needed.

Risk Factors Addressed

Early and persistent antisocial behavior Family management problems

Protective Factors Addressed

Skill building - Parenting

CSAP Strategy

Education

Type of Strategy

Selective

Populations Appropriate for This Best Practice

- Families at-risk with children from early elementary to high school age
- Parents with illiteracy barriers

Evaluating This Best Practice

This best practice comes with an evaluation tool that can be used when implementing this strategy.

Evaluation Tool Cost:

There is no cost for the tool. Please call the phone number in the "Contact" box below for data analysis costs to be negotiated with the developer.

The following are suggested areas to assess when implementing this practice:

- · Assess change in family management skills
- · Assess change in child behavior problems

Research Conclusions

(Excerpt from Strengthening America's Families' web site http://www.strengtheningfamilies.org/index.html and from Dr. Gordon)

A pre/post-test evaluation format was used which showed that parents had improved knowledge of parenting principles, use of appropriate parenting skills, and decreased child behavior problems. Almost half of the teens who scored in the clinically deviant range of the Eyberg Child Behavior Inventory had moved into the functional (normal) range of child behavior. A third evaluation showed the same kinds of changes as found in the first two studies, except the magnitude of changes in child behavior problems was greater. Problem behaviors had dropped to half of the previous rate one, three, and six months after the parents used the program. A control group showed no changes.

A fourth evaluation with teen parents found, relative to a control group, that the program produced significant improvements in parenting knowledge and application of principles to dealing effectively with toddlers. A fifth evaluation found that parents of problem middle school students reported 60% fewer problem behaviors four months after using the program, compared to a control group who reported no changes.

A sixth evaluation evaluated the program delivered via a laptop computer in the homes of severely disadvantaged families. Parents and their 4th to 6th graders reported im-

proved family relationships and lower family risk factors for delinquency and substance abuse relative to a comparison group reading parenting brochures. Both groups reported improvements in child problem behavior, with the CD-ROM group reporting more changes.

A seventh evaluation comparing delivery formats for the CD-ROM indicated there may be more improvements in child problem behavior when the program was used in groups than individually. An eighth evaluation with high school students who received either the CD-ROM in group format or the usual parent education classes found improvements in knowledge of parenting principles and skills only for the CD-ROM group, when the program was used in groups than individually.

Costs as of December 2001 (Subject to Change)

Note: Training is optional and is primarily motivational to encourage community service providers to use the Parenting Wisely program. The PW program is self-administered, therefore professionals do not need training in its use.

Training Time:

4 - 8 hours depending upon group size and experience

Training Cost:

\$2,000 for a one-day training, plus \$1,000 additional fee if travel time is greater than a half day, and per diem. An associate (doctoral student) one-day training is \$1,000 plus travel and per diem.

Strategy Implementation:

\$2,450 for 100 participants plus

\$1,700 if a desktop computer and laptop computer must be purchased

\$2,000 (\$20 per family) for incentives to increase parental cooperation for high risk families (optional)

The \$2,450 figure includes the following:

- Two CD-ROM kits (one American English and one Spanish, or one American English and one British English)
- · One videotape series
- · 100 Parent workbooks

This CD-ROM program comes with a kit. The kit includes:

- A manual for community implementation
- Five parent workbooks
- Program completion certificates
- Program brochures
- · Referral cards
- Poster
- Brief motivational video for parents

· A floppy disk containing evaluation forms and evaluation instructions

The program is also available in Spanish, at the same price, and quantity discounts are available for multiple kits. There is also a British version of the program, with a different design and different actors, to be used when parents repeat the program. The program is also available in an abbreviated and non-interactive form on a set of three videotapes that can be used as a booster for in-home use after the family has used the CD-ROM.

Special Considerations

Please consider the following before selecting this strategy for your community:

- · Reading level of program is 5th grade, but for illiterate parents the program text can be read aloud by the program itself.
- The best locations for program implementation are at accessible social service agencies, schools, or public libraries.
- To reach the most resistant parents, we recommend home delivery of the program via a laptop computer. In this way, several family members can use the program together, increasing the interaction and possibly the benefit of the program.
- The program developers and others have had much success calling at-risk families and offering them \$20 for feedback about their views of the program. They offer to bring the program to their home, and present this approach similar to a marketing survey. In this way, parents do not feel singled out or blamed.

Contact Information

For materials, ordering, or for training information, contact: Family Works, Inc.

20 E. Circle Drive. Suite 190

Athens, OH 45701

E-mail: familyworks@familyworksinc.com

Phone: 740.593.9505 (EST) or

541.201.7680 (PST)

Fax: 740.593.0186

Web site: http://www.familyworksinc.com or

www.parentingwisely.com

Dr. Gordon may be contacted via e-mail:

E-mail: gordon@ohio.edu

BEST PRACTICE: Parenting and Family Skills Program: Helping the Noncompliant Child

Description of Best Practice

(Excerpt from *Strengthening America's Families: Promising Parenting Strategies for Delinquency Prevention, Office of Juvenile Justice and Delinquency Prevention, 1993, pp. 58-60.*)

Program Objectives

Primary goals are secondary prevention of serious conduct disorder problems in preschool and early elementary schoolaged children, and the primary prevention of subsequent juvenile delinquency. Short-term and intermediate objectives include:

- a) Disruption of coercive parent-child interactions and the establishment of positive, pro-social interactions
- b) Improved parenting skills in tracking the child's positive behaviors, increased use of praise and positive statements, ignoring of minor inappropriate behaviors, provision of clear and appropriate instructions, and provision of appropriate consequences for compliance, noncompliance, and other behaviors
- c) Increased child pro-social behaviors and decreased conduct problems.

Program Strategies

The parent training program focuses on teaching parents to change maladaptive patterns of interaction with their children. The 60 to 90 minute sessions are conducted in a clinic setting with individual families rather than in groups. In an ideal setting, sessions occur in clinic playrooms equipped with one-way mirrors for observation, sound systems, and sound devices by which the therapist can communicate unobtrusively with the parent; however, these are not necessary for the successful implementation of the program.

This active program places a great deal of emphasis on helping the parent become competent and comfortable with the various parenting skills taught in the program. Progression to each new parenting skill in the program is based on the competent performance of the earlier skills. This facilitates individualization of the treatment program by allocating training time more efficiently, since the therapist can focus attention on more serious parenting skill difficulties.

The number of sessions needed for completion of each phase of treatment depends on the speed with which the parent demonstrates competence and the child's response to treatment. The average number of sessions is 10-12. Sessions are typically held once or twice weekly.

Staffing

A single family therapist is all that is necessary to conduct the program successfully. However, if resources permit, use of a co-therapist can increase the therapist's flexibility in demonstrating various skills to the parent (e.g., the therapist and co-therapist may demonstrate these by role-playing the parent and child).

Resources Needed and Materials Available

A comprehensive presentation of the program is contained in the therapist's manual (Forehand & McMahon, 1981). Parents are provided handouts specific to each skill for reference in the home setting, are assigned homework to practice their newly acquired skills, and are given data sheets to record their results.

Special Characteristics

This social-learning based program consists of two phases. Phase I (the differential attention phase) helps the parent to use positive verbal and physical attention contingent upon compliance and other appropriate behaviors, and to ignore minor inappropriate behavior. Phase II teaches the parent to use clear instructions and to provide appropriate consequence for child compliance and noncompliance. The parent learns to issue instructions one at a time that are clear, concise, and direct, and to allow the child sufficient time to comply. The parent is taught to praise or attend to the child within 5 seconds of compliance initiation. A time-out procedure is used when the child is noncompliant. Standing rules are designed and implemented for each child.

Comments on Implementation/Replication

As with other programs that require a trained therapist, the costs of this program may make it difficult for some agencies to implement.

Risk Factors Addressed

Early antisocial behavior

Protective Factors Addressed

Bonding: Family

CSAP Strategy

Information dissemination Education

Type of Strategy

Selective

Populations Appropriate for This Best Practice

- Parents and their three- to eight-year-old children who are exhibiting noncompliance and other conduct problems, such as attention-deficit hyperactivity disorder
- Mothers at risk of child abuse and neglect
- Parents of children with handicaps

Evaluating This Best Practice

This best practice does not come with an evaluation tool that can be used when implementing this strategy.

The following are suggested areas to assess when implementing this practice:

· Assess decrease in conduct problem behaviors such as

aggression, tantrums, destructiveness, and inappropriate verbal behavior.

• Assess improvements in child compliance

Research Conclusions

(Excerpt from Strengthening America's Families: Promising Parenting Strategies for Delinquency Prevention, Office of Juvenile Justice and Delinquency Prevention, 1993, pp. 59-60.)

This parent training program has been extensively evaluated (see McMahon & Forehand, 1984).

- · Parent and child behaviors have been shown to improve in the home to within the normal range as a function of treatment as have parents' perceptions of their child's adjustment. Furthermore, these improvements occur regardless of the families' socioeconomic status (although families from lower socioeconomic backgrounds are less likely to complete the program) or age of the children (within the three to eight year-old range).
- Improvement in child compliance has been shown to be accompanied by decreases in other conduct problem behaviors such as aggression, tantrums, destructiveness, and inappropriate verbal behavior.
- Maintenance of effects has been demonstrated in a series of studies with follow-up assessments ranging from six months to more than 14 years after treatment termina-

Parents have also indicated high levels of satisfaction with the parent training program. The parent training program has also been successfully employed with other high-risk populations, including:

- Children with handicaps (Hanf & Kling, 1973)
- Those with attention-deficit hyperactivity disorder (Pisterman, Mcgrath, Firestone, Goodman, Webster, & Mallory, 1989)

- · Mothers at risk of child abuse and neglect (Wolfe, Edwards, Manion, & Koverola, 1988)
- And as a component of a preventative intervention for children of alcohol and drug abusing parents (Kumpfer & Demarsh, 1987)

Costs as of December 2001 (Subject to Change)

Training Time: Two days

Training Cost: \$3,000 (\$1,500/day plus expenses)

Note: Training is not required but highly recommended. There are qualified trainers in most areas of the country. Onsite practice and follow-up supervision have been found to be extremely helpful in implementing this program. Additional consultation and technical assistance are available and are usually negotiated on an individual basis. There is no minimum number of training participants; however, there is a ceiling of 16-20 participants in a training session. The trainer's manual, training videotape, and self-help book for parents must be purchased separately. A new trainer's manual (McMahon & Forehand, 2001) will be published in 2003.

Special Considerations

None specified by the authors of this program

Contact Information

For inquiries about training, technical assistance, materials, or for more information contact:

Robert J. McMahon, Ph.D. University of Washington Department of Psychology, Box 351525 Seattle, WA 98195-1525

E-mail: mcmahon@u.washington.edu

Phone: 206.543.5136 Fax: 206.685.3157

BEST PRACTICE: Parenting Skills Program

Description of Best Practice

(Excerpt from materials provided by Parenting Skills Program staff in January 2002.)

Program Origin

The Parenting Skills Program for problem prevention and enrichment was developed in the mid and late 1970s. It is an offshoot of the Filial (parent-child) Therapy program that has been actively employed since the early 1960s. The therapy program is the work of Bernard Guerney, Ph.D. The adaptation for training birth, adoptive, and foster parents for non-therapeutic application was developed by Louise Guerney, Ph.D. The Guerneys are both Professors Emeritus from Pennsylvania State University, where the development, application, and research were done on these programs.

Program Objectives

Primary program objectives are to teach parents communication skills and child management skills that will result in improved parent-child relationships and foster good psychosocial adjustment in the children. Parent use of these skills is related to freedom from drug and alcohol abuse, delinquency, teen-aged pregnancy, and school dropout. Improved academic performance and pro-social skills are expected.

Program Strategies

Training techniques include minimal readings and homework assignments, mini-lectures, skills training, and practice with feedback. The emphasis is on skills acquisition and practice but discussion for processing the skills is built into the lessons. There is much flexibility in the program format. It can be offered to a single parent, a single family, or a group of parents. Typical groups are 12 to 16 parents in number with one or two leaders.

The most commonly used format is eight lessons but sixand ten-week formats are also laid out in the leader's manual for use when time is short or when ten weeks are possible. The number of skills is not reduced in the six-week format but the amount of time for practice and discussion must be reduced. Nonetheless, parents taking the six-week course show positive pre-post gains. The ten-week format allows either extra skills practice or extra discussion lessons on topics pertinent to the group or family, e.g., parenting children with special needs. The eight-week format requires 16 hours to cover which may be offered in two-hour weekly sessions, in a weekend, or in daylong sessions. Times can be tailored to meet the requirements of the parents.

Staffing

No special educational or professional background is required. Most frequent leaders are prevention specialists, Head Start staff, social workers, and counselors, but anyone properly trained to use the program may offer it. Training is provided through a non-profit institute, IDEALS (Institute of the Development of Emotional and Life Skills).

Certification as a trainer and a trainer supervisor is available. IDEALS trainers travel throughout the United States and Canada. Training fees include a daily fee plus travel and

per diem expenses. Usually 12 enrollees for leadership training are necessary to make the per-trainee cost reasonable. Follow-up supervision is available via audio or videotape and telephone if the training site is distant from IDEALS' location in Bethesda, Maryland. Certification requires follow-up supervision.

Resources Needed and Materials Available

Leaders' and parents' manuals are available and a videotape with vignettes of children presenting parenting dilemmas for parents to respond to.

Risk Factors Addressed

Family management problems

Protective Factors Addressed

Bonding: Family

CSAP Strategy

Information dissemination Education

Type of Strategy

Universal Selective

Populations Appropriate for This Best Practice

- · Foster parents
- · Parents of low socioeconomic status
- · Parents of varying religious backgrounds
- · Parents from inner-city and rural areas

Evaluating This Best Practice

This best practice comes with an evaluation tool that can be used when implementing this strategy.

Evaluation Tool Cost: \$5.00 per form

This includes scoring information and explanations of the administration. The forms may be duplicated without charge as long as the measure is properly identified and source cited.

The measure is ten pages long and has two equivalent forms — one to be used for the pre-test and one for the post-test. The questions are multiple choice and center around parent-child dilemmas. They are intended to measure whether the parents mastered the skills taught. They do not measure changed attitudes or behaviors. For the latter, standard measures such as the Parenting Stress Index (Richard Albin) have been used.

The following suggestion is an area you may want to assess if you implement this best practice:

· Assess the increase in family management skills

Research Conclusions

(Excerpt from *Strengthening America's Families: Promising Parenting Strategies for Delinquency Prevention*, Office of Juvenile Justice and Delinquency Prevention, 1993, p. 39.)

The program has been very thoroughly investigated in its foster parent form. In relation to foster parents, parental acceptance and parenting skills improve significantly on prepost tests. FPSTP outcomes were significantly higher for both parents and their foster children than the outcomes of a control group. These significant changes in parent attitudes, skills acquisition, and caseworker evaluation of family and children continued over a period of five years for six waves of parent trainees. Trainers taught to offer the program showed positive changes in relation to their own skill use and job performance. (Three reports from IDEALS are available on these results.)

In relation to the infant version, parents in the local Childbirth Education Association, trained to conduct the program, were able to bring about significant pre-post changes in parents of babies six months and younger in age. These results were significantly more positive than a comparable new mother-support/discussion group offered during the same pre-post period.

Costs as of January 2002 (Subject to Change)

Preferred Training Time:

21 hours to train parent leaders. This includes three hours supervision while offering the course for the first time.

Optional Training Time:

Two very intensive eight-hour days. Additional follow-up supervision would be recommended.

Training Cost:

\$1,200 per day for the primary trainer. If the number of trainees is large, e.g., if a few agencies combine for the training, a second trainer or even a third would be required to provide the small group practice needed for conducting mock group sessions with trainees role-playing difficult and challenging parents playing the roles that parents are known to do in real training sessions. Issues of recruitment, retention, and cooperation with community resources are also covered. Additional trainers would be paid the same fee as the primary trainer. Travel and per diem expenses would be paid to trainers in addition to the training fees.

Strategy Implementation Cost:

Required would be manuals for the parent leaders at \$24.95 each and manuals for the parents who will participate. These cost \$9.95 each with a 40% discount for bulk purchases, i.e., 12 or more. Adolescent supplement manuals are needed if the target population is primarily adolescents and/or adolescents are a secondary issue for participating parents. These

cost \$9.00 each. Leaders' manuals are not available until leaders have actually enrolled in the leadership training program. Parent manuals may be purchased at any time. Optional is the videotape with the vignettes mentioned above. This is \$79.95 plus shipping and handling, and is purchased from the Pennsylvania State University Audio-Visual Service, University Park, PA 16802.

Additional Cost:

Reproduction costs for parents' program feedback form and information handouts for parents. Supervision costs would be additional and would depend on whether supervision was by phone or on-site.

Special Considerations

Please consider the following before selecting this strategy for your community:

- · The parent's manual is at a sixth-grade reading level that makes it quite manageable for most parents.
- · It is best to implement the program in a place where parents are comfortable, e.g., a day care center, Head Start Center, or local church.
- Parent educators must have time available among their other duties to master the offering of the course and give it on a predictable basis. The practice can be truly preventive in that taking it before parent-child problems require treatment can divert the family from the treatment route. This frees up agency staff to provide treatment to fewer parents.

Contact Information

For information on training or materials, contact:

Laura Landi

301.622.4339 Phone:

or.

Louise F. Guerney, Ph.D.

c/o National Institute of Relationship Enhancement (NIRE)

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North Bethesda, MD 20852

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Phone: 301.231.6148 Fax: 301.231.6151

BEST PRACTICE: Parents As Teachers

Description of Best Practice

(Excerpt from Strengthening America's Families' web site, http://www.strengtheningfamilies.org/index.html with modification by Parents As Teachers staff on August 2, 2001.)

Parents as Teachers (PAT) is an international family education and support program that begins prenatally-the onset of learning-and extends to kindergarten entry. Acknowledging that parents are the first and most influential teachers of their children, the program's primary goal is to help families lay a strong foundation for children's success in school and in life. PAT provides appropriate ways parents can stimulate their children's intellectual, language, social, and motor skills, thus enhancing parent-child interaction and strengthening family relationships. The program provides screening of children for early detection of developmental, health, hearing and vision problems, and helps communities by building a strong partnership between parents and schools. The program meets the needs of broadly diverse families, cultures and special populations including teen parents, parents of children with special needs, families facing critical issues, families living on American Indian reservations, families who are homeless and formerly homeless, and those living on military bases. The program is also adapted for center-based providers.

The program provides the following services:

- Personal visits-PAT-certified parent educators, help parents understand and have appropriate expectations for each stage of their child's development
- 2) They use the Born to LearnTM Curriculum to bring the latest neuroscience research findings to parents, offering practical ideas on ways to encourage learning and interact with their children
- Group meetings- parents meet to enhance their parenting knowledge, gain new insights and share their experiences, common concerns and successes
- 4) Developmental screenings—Parents as Teachers offers periodic screening of overall development, health, hearing, and vision to provide early detection of potential problems and prevent later difficulties in school and
- 5) Linkage to a resource network–families are helped to access other needed community services that are beyond the scope of the PAT program.

Risk Factors Addressed

Academic failure beginning in late elementary school

Protective Factors Addressed

Bonding – Family Skills – Parenting

CSAP Strategy

Education

Type of Strategy

Universal

Populations Appropriate for This Best Practice

Parents with children ages 0-5

Evaluating This Best Practice

This best practice does not currently come with an evaluation tool that can be used when implementing this strategy. However, an evaluation tool is currently being developed.

The following are suggestions of areas you may want to assess if you implement this best practice:

- Assess the language, social development, problem solving, and other cognitive abilities of the PAT children
- Assess the results of kindergarten readiness tests of the PAT children
- Assess the results of standardized measures of achievement in early grades of the PAT children
- Assess PAT families' rates of suspected or documented incidents of child abuse and neglect
- Assess results of PAT screenings and referrals to track vision, hearing, and overall development
- Assess changes in PAT parents' knowledge of child development, parenting attitudes, and parenting behavior with a focus on parent/child reading behavior, home literacy, literacy promoting behaviors, and quality of parent/child interaction
- Assess PAT parents' involvement in their children's schools

Research Conclusions

(Excerpt from Parents as Teachers' web site, http://www.patnc.org/researchevaluation.asp)

Independent evaluations continue to confirm the positive impact of PAT on both parents and children:

Child outcomes

- PAT children at age 3 are significantly more advanced in language, problem solving and other cognitive abilities, and social development than comparison children.
- The positive impact on PAT children carries into elementary school.
- PAT children score higher on kindergarten readiness tests and on standardized measures of reading, math and language in first through fourth grades.

Parent and family outcomes

- PAT parents are more involved in their children's schooling.
- PAT parents are more confident in their parenting skills and knowledge.

PAT families have lower rates of suspected or documented incidents of child abuse and neglect than comparison groups or state averages.

Cost as of December 2001 (Subject to Change)

Training Time:

5 days plus one day of technical assistance

Training Cost:

- Cost to attend the Born to Learn™ Institute runs from \$475 to \$625 per participant depending on location of the training. A sixth day of technical assistance within six months of the institute is included in this price.
- Supervisors of parent educators are required to attend the first two days of the Born to LearnTM Institute at a cost of \$25. Specialized trainings are also available.
- If your program serves teen parents, families facing critical issues or have children with special needs there are additional two-day trainings available that range in price from \$240 to \$365.
- Cost to attend the two-day 3 to 5 Training is \$265-\$340 depending on the location. (Prices include the cost of curriculum.)

Implementation Cost:

In order to implement a Parents as Teachers program, there must be established funding and a supervisor with at least one parent educator. Each parent educator must attend the complete Institute, pass the daily assessments, and submit an approved implementation plan. The major cost of implementing a PAT program is the salary and travel of the parent educators. Most PAT parent educators, on average, are paid \$17 an hour depending on location of the program. Many work part-time (20 hours a week), serving 20 families with monthly visits and additional visits where needed. Some programs hire parent educators on a full-time basis. Total costs for programs including facility charges, program materials such as activities and books, and annual recertification fees (\$35 per parent educator) depend on the amount of in-kind donations of the sponsoring organization. PAT parent educators use, and encourage families to use, resources that are readily available in the home for parentchild activities.

A program purchases a set of Born to LearnTM Curriculum materials (two modules and a 16-segment video series) for

every parent educator. The curriculum costs \$275 and belongs to the program. One Program Administration Guide must also be purchased by each program at a cost of \$25. All these materials are copyrighted by the Parents as Teachers National Center, Inc., and are to be used in certified PAT programs only.

Special Considerations

The following should be taken into consideration before selecting this strategy to be implemented in your community:

- Sustainable funding is needed to support Parents As Teachers over time.
- Collaboration of groups in the community is essential, including Head Start, the school district, and other early childhood programs.
- All four components of the program need to be implemented, including home visiting, health and developmental screenings, group meetings, and linkages to resources.
- An implementation plan has to be submitted prior to implementing Parents as Teachers.

Contact Information

For more information on this program, visit:

Web site: http://www.patnc.org

For more information, contact:

Public Information Specialist

Parents as Teachers National Center, Inc.

10176 Corporate Square Drive, Suite 230

St. Louis, MO 63132

E-mail: patnc@patnc.org

Phone: 314.432.4330 x296

Fax: 314.432.8963

For information about training, contact:

Marilyn Kugman, National Training Coordinator

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BEST PRACTICE: Parents Who Care

Description of Best Practice

(Excerpt from Strengthening America's Families' web site http://www.strengtheningfamilies.org/index.html, updated by Channing Bete Company in December 2001.)

Parents Who Care (PWC) is an educational skill-building program created for families with children between the ages of 12-16. PWC, developed by David Hawkins, Ph.D., and Richard Catalano, Ph.D., is an extension of Preparing for the Drug Free Years. The objective of PWC is to reduce risk factors and strengthen protective factors that are know to predict later alcohol and other drug use, delinquency, violent behavior, and other behavioral problems in adolescence. The PWC program is grounded theoretically in the social development model which emphasizes that young people should experience opportunities for active involvement in family, school, and community, should develop skills for success, and should be given recognition and reinforcement for positive effort and improvement. PWC focuses on strengthening family bonds and establishing clear standards for behavior, helping parents more appropriately manage their teenager's behavior while encouraging their adolescent's growth toward independence. In this process, PWC seeks to change specific risk and protective factors for problem behaviors in the family and peer domains: parent and sibling drug use, positive parental attitudes towards drug use, poor and inconsistent family management practices, family conflict, low family communication and involvement, family bonding, and association with delinquent and drug using peers behaviors.

The program is designed to be led by a facilitator and taught once a week in 5 to 6 sessions lasting 1-2 hours. The program is very flexible and can be facilitated through schools, healthcare organizations, civic organizations, social service organizations, and faith institutions. Parents that attend the workshops are provided with their own parent module for use at home. The PWC book consists of seven chapters and corresponding video segments. The video follows four ethnically diverse families as they struggle with the issues and emotions that many parents confront.

The program is structured around three major topics:

- setting the stage, which covers the importance of risk and protective factors
- 2) the power of communication, and
- 3) family management

Risk Factors Addressed

Family management problems
Parental attitudes favorable towards drugs, crime and violence
Antisocial behavior

Protective Factors Addressed

Bonding – Family Skills – Parenting

CSAP Strategy

Information dissemination Education

Type of Strategy

Universal Selective

Populations Appropriate For This Best Practice

Families with adolescents ages 12-16 who are at risk for developing problems with alcohol, drug use or delinquency

Evaluating This Best Practice

This best practice comes with a pre-post test evaluation tool that can be used when implementing this strategy.

Evaluation Tool Cost:

Included in the cost of the curriculum. However, the tool must be requested, as it is not routinely included with the curriculum.

The following are suggestions of areas you may want to assess if you implement this best practice. (For assistance on creating an evaluation plan, refer to Step 7: Evaluation.)

- Assess the family management skills of participating parents.
- Assess participating parents' attitudes towards drugs, crime and violence.
- Assess the occurrence of antisocial behavior in youth of participating parents.

Research Conclusions

(Excerpt from Strengthening America's Families' web site, http://www.strengtheningfamilies.org/index.html updated by Channing Bete Company in December 2001.)

An experimental evaluation was conducted with 66 families with adolescents ages 12 to 16. The families were self-identified as having adolescents who were at risk for developing problems with alcohol, drug use, or delinquency. The research design was a pre-test post-test design with random assignment to either a treatment (n = 35) or wait-list control group (n = 31). Analyses revealed significant differences in risk and protective factors targeted by the intervention at post-test between the two groups. Results for parent participants indicated that the treatment group showed a statistically significant improvement in three areas: 1) family discipline, 2) family attitudes favorable to antisocial behavior, and 3) level of family bonding. The treatment group

at post test also showed lower levels of risk factors of poor family supervision and low parental commitment to school. Overall, the initial evaluation shows promise for changing family-focused risk and protective factors.

Costs as of December 2001 (Subject to Change)

Training Time and Cost:

No training is necessary to implement this program. However, if desired, technical assistance is available.

Implementation Cost:

To conduct a PWC parent group, only one discussion leader is needed who has facilitation experience and who is familiar with the basic elements of learning theory and its application to both adolescents and adult learning. The facilitator should be familiar with the content of PWC and be able to adapt the program to fit specific community needs.

The program package contains everything needed to hold the parent discussion groups including one Facilitator's Manual complete with video and workbook, activities, blackline masters, discussion questions, resources and ten parent modules for \$1,200.00. Additional facilitator and parent modules are available at \$299.00 and \$99.00, respectively. To encourage parent participation, transportation to the location should be considered and childcare would be beneficial for younger children accompanying the parents. Also, providing the individual parent modules at no cost or at a nominal fee would be helpful.

Special Considerations

The following should be taken into consideration before selecting this strategy to be implemented in your community:

- The age of youth included in this program is typically 12-16. It is not recommended for use with youth younger than 13 or older than 18.
- This curriculum is available in Spanish.

Contact Information

For general information, contact:

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BEST PRACTICE: Perry Preschool Project – High/Scope Approach

Description of Best Practice

(Information provided by Gavin Haque of High Scope Education Research Foundation, June 28, 2001.)

The High/Scope Approach is utilized in thousands of infant/toddler, early childhood, elementary, and adolescent programs around the world. The approach, based on the work of Jean Piaget and other constructivists, calls for teachers sharing control with their students while providing exciting classroom experiences based on children's strengths, needs, and interests.

Research from the High/Scope Perry Preschool study indicates that such an intervention program promotes the general welfare of students and their families through greater employment opportunities, lower participation in welfare programs, lower teenage pregnancy rates, and a decrease in violent crime.

The High/Scope Approach can be implemented in many types of settings: center-based, home-based, and shared environments. Successful programs that implement High/Scope's approach share the following characteristics:

- A developmentally appropriate curriculum that views children as active, self-initiated learners.
- Small classrooms of 20 children and at least two staff who allow a more supervised and supportive learning environment.
- Staff who are trained in early childhood development and education, who receive supervision and on-going instruction, and who actively communicate with parents.
- Sensitivity to the non-educational needs of disadvantaged children and their families, which includes providing meals and recommending other social service agencies.
- Ongoing monitoring and evaluation of both teachers' activities and children's behaviors and development.

Risk Factors Addressed

Early and persistent antisocial behavior Academic failure Low commitment to school Economic deprivation

Protective Factors Addressed

Skills: Academic Bonding: School

CSAP Strategy

Education

Type of Strategy

Selective

Populations Appropriate for This Best Practice

· Low socioeconomic families

· African Americans

Evaluating This Best Practice

This best practice comes with an evaluation tool that can be used when implementing this strategy. The High/Scope Child Observation Record (COR) provides an opportunity to track children's development throughout the program year. For a cost of \$90.95, teachers can assess a classroom of twenty-five students on three occasions. Additionally, the High/Scope Program Quality Assessment (PQA) allows teachers to critique the effectiveness of their programs and make modifications based on the elements of quality- Active Learning, Adult/Child Interaction, Learning Environment, and Parent Involvement.

The following are suggested areas to assess when implementing this practice:

- · Assess antisocial behavior and misconduct of participants
- Assess academic achievement, including grades and scores on standardized tests
- Assess commitment to school, including attitudes toward school

Research Conclusions

(Excerpt reprinted with permission from the Center for the Study and Prevention of Violence, Institute of Behavioral Science, Regents of the University of Colorado, http://www.Colorado.EDU/cspv/blueprints/promise/perPre.htm)

Evaluations have demonstrated a wide range of successful outcomes for children who participate in programs that use High/Scope teaching strategies, compared to those who did not receive intervention, including:

- Less delinquency, including less contact with juvenile justice officials, fewer arrests at age 19, and less involvement in serious fights, gang fights, causing injuries, and police contact
- Less antisocial behavior and misconduct during elementary school and at age 15
- Higher academic achievement, including higher scores on standardized tests of intellectual ability and higher school grades
- Fewer school dropouts at age 19 (33% vs. 51%) and higher rates of high school graduation
- Greater commitment to school and more favorable attitudes about high school
- Higher rates of employment (50% vs. 32%) and pay, and greater job satisfaction
- Greater economic independence and less reliance on public assistance, including welfare usage
- Fewer pregnancies and births for women at age 19

Costs as of May 2001 (Subject to Change)

Training Time: Varies

Training Cost:

\$2,850 per person; training costs vary by group size. The rate given is for 20 people, 4 weeks of training at 30 hours per week.)

Strategy Implementation:

The program costs \$57,000 for 20 participants.

Special Considerations

Please consider the following before selecting this strategy for your community:

• The High/Scope curriculum framework has proven effectiveness in preventing school failure, dropout, and crime with disadvantaged children.

Contact Information

For training, technical assistance, and materials contact:

Gavin Haque

High Scope Educational Research Foundation

600 North River St

Ypsilanti, MI 48198-2898

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Phone: 734.485.2000 or

800.407.7377

Fax: 734.485.0704

Web site: http://www.highscope.org

BEST PRACTICE: Preparing for the Drug Free Years

(Hawkins and Catalano)

Description of Best Practice

(Excerpt from materials provided by Channing Bete Company in December 2001.)

Preparing for the Drug Free Years (PDFY) is a multimedia program developed by David Hawkins, Ph.D., and Richard Catalano, Ph.D., which provides parents of children in 4th through 8th grades the knowledge and skills they need to guide their children through early adolescence. The program aims to strengthen and clarify family expectations for behavior, enhance the conditions that promote bonding in the family, and teach skills to parents and children to successfully meet the expectations of their family and resist drug use.

Over the last 20 years, research has shown that positive parental involvement is an important protective factor that:

- · Increases school success
- Buffers children against later problems such as substance abuse, violence, and risky sexual behaviors

PDFY is made up of the following components:

- A Workshop Leader's Guide, which includes masters for parent handouts
- · A Family Guide
- A videotape with five vignettes (one for each parent session)
- · A complete set of transparencies on CD

A PDFY workshop kit contains:

- · Two Workshop Leader's Guides with CD
- Two videos
- One Family Guide (A Family Guide is needed for each participating family.)

The program is comprised of five two-hour sessions usually held over five consecutive weeks. Curriculum can also be presented in ten one-hour sessions. The sessions are interactive and skill based, with opportunities for parents to practice new skills and receive feedback from workshop leaders and their parent peers. Video-based vignettes demonstrate parenting skills through the portrayal of a variety of family situations. Families are provided with a Family Guide containing family activities and discussion topics, as well as skill-building exercises and information on positive parenting.

Session topics include:

- · How to Prevent Drug Abuse in Your Family
- Setting Clear Family Expectations on Drugs & Alcohol
- · Avoiding Trouble
- Managing Family Conflict
- · Strengthening Family Bonds

The program has been offered to parents in schools, worksites, churches, community centers, homes, hospitals, and prisons.

Risk Factors Addressed

Family management problems
Family conflict
Favorable attitudes toward drug use
Parental attitudes and involvement
Friends who use
Early initiation of substance abuse

Protective Factors Addressed

Bonding: Family Opportunities, skills, and recognition Healthy beliefs/clear standards

CSAP Strategy

Information dissemination Education

Type of Strategy

Universal

Populations Appropriate for This Best Practice

- Parents of children in grades 4 8 (ages 9 14)
- · Urban, multi-ethnic communities
- · African American
- Native American
- Hispanic/Latino
- Asian/Pacific Islander
- Caucasian

Evaluating This Best Practice

This best practice comes with an evaluation tool that can be used when implementing this strategy. The tool is available upon request and includes a pre- and post-written test.

Evaluation Tool Cost:

There is no cost for this tool.

The following are suggested areas to assess when implementing this practice:

- Assess increased parenting skills
- · Assess increased family bonding

Research Conclusions

(Excerpt from Channing Bete Company in December 2001.)

 Significant effects on targeted parenting behaviors were found at post-test and maintained one year later. Results of dissemination studies showed increased parental knowledge about the family's role in prevention, unfavorable parental attitudes towards drug use, and increased use of family meetings to prevent drug use in children.

- · At the two-year follow-up, youth in the PDFY group who had not initiated substance use at the one-year follow-up were significantly more likely to have remained non-users by the two-year follow-up than their counterparts in the control group. Youth in the PDFY group who had initiated substance use at the one-year follow-up were significantly less likely than youth in the control group to have progressed to more frequent or varied drug use by the two-year follow-up.
- At the 3.5 year follow-up, youth in the PDFY group had significantly lower growth in initiation rates for drunkenness and marijuana use than the youth in the control group. The PDFY group also had a significantly lower proportion of youth who reported using alcohol during the previous month, lower frequencies of alcohol use, and lower growth of alcohol use frequency.
- Further analyses showed youth in the PDFY group had significantly less growth in alcohol use (a combined measure of initiation, frequency, and defying parent's alcohol rules), and significantly higher parental norms against alcohol and other drug use than the control group three and one-half years after the intervention (Park, Kosterman, Hawkins, Haggerty, Duncan, Duncan & Spoth, 2000).

Costs as of December 2001 (Subject to Change)

Training Time: Three days

Training Cost:

\$4,500 plus \$100 per participant up to 12 participants, plus travel costs for one trainer

Strategy Implementation:

\$695 plus shipping for the curriculum kit that is purchased separately. The kit includes training materials for two workshop leaders to train parents. Volume discounts are available for the purchase of the Family Guide.

Special Considerations

Please consider the following before selecting this strategy for your community:

• This parent education program is for parents of children in grades 4 - 7

Contact Information

For general information, contact:

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BEST PRACTICE: Project ACHIEVE

Description of Best Practice

(Excerpt from "Research-Based Program Models" by the Center for Prevention Research and Development for *Illinois Prevention 2000*, July 1998, pp. 59-60.)

Project ACHIEVE is an innovative school reform program developed for use in elementary and middle schools (students 6 to 14 years old). It is designed to help schools, communities, and families develop, strengthen, and solidify their youths' resilience, protective factors, and self-management skills. Project ACHIEVE works to improve school and staff effectiveness, and places particular emphasis on increasing student performance in the areas of: (a) social skills and social-emotional development; (b) conflict resolution and self-management; (c) achievement and academic progress; and (d) positive school climate and safe school practices.

Objectives

- Enhance the problem-solving skills of teachers such that effective interventions for social (in particular violence) and academic difficulties of at-risk students are developed and implemented.
- Improve the building and classroom management skills of school personnel and the behavior of students to create a disciplined environment within which to learn through the use of a building-based social skills and aggression control training program.
- Improve the school's comprehensive services to students with below-average academic performance such that they are served, as much as possible, in the regular classroom setting and have equal access to high-quality educational programs.
- Increase the social and academic progress of students through enhanced involvement of parents and the community in the education of their children.
- Create a school climate in which each teacher, staff member, and parent believes that everyone is responsible for every student in the school building and community.

Intervention

Project ACHIEVE is implemented in a series of sequenced steps over a three-year period. Before implementation, a detailed overview is provided to the entire school staff, and an 80 percent acceptance vote is required to implement the program. Once accepted, an organizational analysis and needs assessment is completed, a pupil personnel support team is identified, and pre-project baseline data is collected.

Project ACHIEVE's components include the following:

- Strategic planning and organizational analysis and development.
- Referral Question Consultation (RQC) problem solving process

- Effective classroom and school processes/staff development
- Instructional consultations and curriculum-based assessment and intervention
- Social skills, behavioral consultation, behavioral interventions, and school safety
- · Parent training, tutoring, and support
- · Research, data management, and accountability

Training is facilitated by pupil services personnel and involves regular and special education teachers, bus drivers, school staff (custodial, cafeteria, office) parents, and volunteers. A "training of trainers" model is also used.

Risk Factors Addressed

Academic failure Lack of commitment to school

Protective Factors Addressed

 $Skills: \ Problem \ solving, \ social \ skills, \ anger-reduction$

techniques Bonding: School

CSAP Strategy

Education Environmental

Type of Strategy

Universal Selective

Populations Appropriate for This Best Practice

- Academically and socially at-risk, and underachieving students
- · Pre-K through middle school settings
- African American and Caucasian students

Evaluating This Best Practice

This best practice comes with an evaluation process and sample protocols/tools that can be used when implementing this strategy.

Evaluation Tool Cost:

There is no cost for these, however at times schools and districts are referred to places that have created software and web sites with evaluation tools and programs. Some of these have additional costs associated with them.

The following are suggested areas to assess when implementing this practice:

- Assess the rate of referrals to and placements in special education.
- Assess the rate of disciplinary referrals to the principal's office.

- · Assess the increase in the number of students scoring above the 50th percentile on end-of-year achievement
- Assess an improvement in teachers' perceptions of school climate.
- · Assess the rate of student grade retentions.
- Assess the rate of out-of-school suspensions.

Research Conclusions

(Excerpt from "Research-Based Program Models" by the Center for Prevention Research and Development for Illinois Prevention 2000, July 1998, pp. 59-60.)

Since its creation in August 1990, the project has achieved the following:

- 75% decrease in student referrals to special education
- 67% decrease in student placements in special education
- 28% decline in total disciplinary referrals to the principal's
- · A decline in student grade retentions from 6 percent of the total student population to .006.
- An increase in the number of students scoring above the 50th percentile on end-of-year achievement tests.
- · An improvement in teachers' perceptions of school cli-
- · Academic improvements for those students whose parents were trained in the Parent Drop-In Center.

Costs as of December 2001 (Subject to Change)

Training Time:

Two workshop days, plus one day of on-site technical consultation

Training Cost:

\$1,500/day plus travel and other expenses

Note: The training goal is to help schools to develop a comprehensive, building-wide discipline, behavior management, and school-safety system with procedures and strategies that focus on prevention, strategic intervention (when needed), and wrap-around approaches for intensive need students.

Strategy Implementation:

Approximately \$8,500 for a three-day in-service, plus technical support and program materials.

This figure includes the following:

- \$4,500: Three-day honorarium
- \$1,500 (estimate): Transportation
- \$2,000: Social-skill teacher manuals/posters/signs/support material
- \$500: Workshop handout duplication costs

Special Considerations

Please consider the following before selecting this strategy for your community:

This is a school-wide effort and consultation/professional

development process. Schools will need to demonstrate (through questionnaire responses) the organizational readiness and staff motivational readiness (through a vote prior to consultation) of the school.

Contact Information

For more information on this program, visit web sites: http://modelprograms.samhsa.gov and

http://www.coedu.usf.edu/projectachieve

For training, materials and technical assistance contact:

Dr. Howard M. Knoff 8505 Portage Avenue Tampa, FL 33647

E-mail: knoff@tempest.coedu.usf.edu

Office Phone: 813.974.9498

Evening (Home) Phone: 813.978.1718

Fax: 813.974.5814

For additional materials: Sopris West Publishers 4093 Specialty Place Longmont, CO 80504 Phone: 800.547.6747

Web site: http://www.sopriswest.com

Additional references:

Knoff, H. M. (2002). Best practices in organizational assessment and strategic planning. In A. Thomas & J. Grimes (Eds.), Best practices in school psychology-IV. Bethesda, MD: National Association of School Psychologists.

Knoff, H. M. (2002). Best practices in personality assessment. In A. Thomas & J. Grimes (Eds.), Best practices in school psychology- IV. Bethesda, MD: National Association of School Psychologists.

Knoff, H. M. (2000). Stop and Think! Steps toward the systematic prevention of student violence. Reaching Today's Youth: The Community Circle of Caring Journal, 5(1), 63-66.

Knoff, H. M. (2000). Organizational development and strategic planning for the millennium: A blueprint toward effective school discipline, school safety, and crisis prevention. Psychology in the Schools, 37, 17-32.

Raffaele, L., & Knoff, H. M. (1999). Improving home-school collaboration with parents of children at-risk: Organizational principles, perspectives, and approaches. School Psychology Review, 28, 448-466.

Quinn, M. M., Osher, D., Hoffman, C. C., & Hanley, T. V. (1998). Safe, drug-free, and effective schools for ALL children: What Works! Washington, DC: Center for Effective Collaboration and Practice, American Institutes for Research.

Knoff, H. M., & Batsche, G. M. (1995). Project ACHIEVE: Analyzing a school reform process for at-risk and underachieving students. School Psychology Review, 24, 579-603.

BEST PRACTICE: Project ALERT

Description of Best Practice

(Excerpt from "Research-Based Program Models" by the Center for Prevention Research and Development for *Illinois Prevention 2000*, July 1998, pp. 61-62.)

Project ALERT is a school-based, social resistance approach to drug abuse prevention. The curriculum specifically targets cigarettes, alcohol, and marijuana use.

Objectives

To enable students to do the following:

- · Develop reasons not to use drugs
- · Identify pressures to use them
- · Counter pro-drug messages
- · Learn how to say no to external and internal pressures
- · Understand that most people do not use drugs
- · Recognize the benefits of resistance

Intervention

Project ALERT is a video-based curriculum designed for sixth and seventh grade, or seventh and eighth grade, students. The first year's program consists of eight lessons, taught a week apart. These lessons are reinforced during three additional lessons in Year 2. The highly participatory curriculum makes extensive use of question-and-answer techniques, small-group exercises, role modeling, and repeated skills practice. These methods allow teachers to adjust program content to diverse classrooms with different levels of information and drug exposure.

Curricular materials include a teacher's manual with 14 detailed lesson plans (11 core plans and 3 booster lessons) two teacher demonstration videos, eight student videos, and classroom posters. Educators must enroll in a participative training workshop to receive the Project ALERT curriculum.

Risk Factors Addressed

Early First Use

Protective Factors Addressed

Skills

CSAP Strategy

Education

Type of Strategy

Universal

Populations Appropriate for This Best Practice

- Sixth and seventh grade students or seventh and eighth grade students
- · Low-risk and high-risk students
- Minority students
- · Various socioeconomic settings

Evaluating This Best Practice

This best practice comes with an evaluation tool that can be used when implementing this strategy.

Evaluation Tool Cost:

There is no cost for the evaluation tool.

The following are suggested areas to assess when implementing this practice:

- · Assess the initiation rate of marijuana and tobacco use
- Assess the rate of tobacco use
- · Assess the acquisition of refusal skills
- Assess the perception that "most people do drugs"

Research Conclusions

(Excerpt from "Research-Based Program Models" by the Center for Prevention Research and Development for *Illinois Prevention 2000*, July 1998, pp. 61-62.)

Evaluation reports conclude that Project ALERT achieves the following:

- Reduces the initiation of marijuana and tobacco use by 30 percent
- Reduces heavy smoking among experimenters by 50-60 percent
- Is effective for both high- and low-risk students, including minorities
- Performs equally well in a variety of socioeconomic settings

Costs as of December 2001 (Subject to Change)

Training Time: Seven hours

Training Cost: \$125 per person

The training cost includes all curriculum materials. Once an educator is trained, he/she will receive print/video updates free of charge. Technical assistance regarding program implementation is also available to all trained educators and is included in the training fee.

Note: Training is required for all educators intending to implement the curriculum.

Special Considerations:

Please consider the following before selecting this strategy for your community:

- Project ALERT is specifically designed for middle school students (6-8 graders) and is best implemented in a regular classroom setting.
- Project ALERT training/curriculum, due to grant restrictions, is not available to after school programs or community organizations unless they are directly involved with a district's Safe and Drug Free School plan.

BEST PRACTICE: Project ALERT 101

Contact Information

For more information on this program, visit web site: http://www.projectalert.best.org and

http://modelprograms.samhsa.gov

For training, technical assistance to trained teachers, and materials contact:

Elena Nogales, VP of Field Operations Project ALERT 725 South Figueroa, Suite 970 Los Angeles, CA 90017

E-mail: enogales@projectalert.best.org

Phone: 800.ALERT.10 or

800.253.7810 x107

Fax: 213.623.0585

Additional references:

Ellickson, P.L., and Bell, R.M. (1990). Drug prevention in junior high: A multi-site longitudinal test. *Science*, 247:1265-1372.

Ellickson, P.L., Bell, R.M. & McGuigan, K. (1993). Preventing adolescent drug use: Long-term results of a junior high program. *American Journal of Public Health*, 83:856-861.

BEST PRACTICE: Project BASIS

Description of Best Practice

(Excerpt from the Northeast CAPT web site, http://www.northeastcapt.org/science/pod)

Project BASIS is a school-wide discipline management program that includes clarifying and enforcing rules, improving classroom organization, and replacing punitive strategies with positive reinforcement. A school improvement team, consisting of teachers and administrators appointed by the principal, leads and coordinates program preparation and implementation by reviewing and revising discipline policies, orienting faculties to the program, developing strategies for implementation, recruiting additional teachers to join the team, monitoring implementation of the new strategies, and providing constructive feedback and technical assistance to teachers and staff.

BASIS includes the following components (excerpt from Gottfredson Associates' "BASIS Program Description"):

- Increasing clarity of school rules and consistency of rule enforcement through revisions to the school rules and a computerized behavior tracking system
- Improving classroom organization and management through teacher training
- Increasing the frequency of communication with the home regarding student behavior through systems to identify good student behavior, and a computerized system to generate letters to the home regarding both positive and negative behavior
- Replacing punitive disciplinary strategies with positive reinforcement of appropriate behavior through a variety of school- and classroom-level positive reinforcement strategies

School teams of administrators, teachers, and other school personnel are responsible for implementing the program. Researchers working with the schools provide quarterly feedback to the teams on the quality of program implementation and on changes in the behaviors targeted by the program.

Risk Factors Addressed

Antisocial behavior

Protective Factors Addressed

Healthy beliefs and clear standards Bonding: School

CSAP Strategy

Environmental

Type of Strategy

Universal

Populations Appropriate for This Best Practice

Middle schools

Evaluating This Best Practice

The following are suggested areas to assess when implementing this practice:

- Assess classroom orderliness, classroom organization and classroom rule clarity
- Assess number of student reports of rewards and punishments
- Assess number of student classroom disruptions

Research Conclusions

(Excerpt from Gottfredson Associates' "BASIS Program Description")

An evaluation involving six implementing middle schools and two comparison schools demonstrated positive effects on the measures most directly targeted:

- Classroom orderliness
- Classroom organization
- · Classroom rule clarity
- Student reports of rewards and fewer punishments

Implementation data showed that the components of the program were implemented with high fidelity to the original design in only three of the six program schools. In these three schools, the positive changes mentioned above were more marked. Also in these schools, teacher support increased, student perceptions of the fairness of school rules increased, teacher reports of student attention to academic work increased significantly, and their ratings of student classroom disruption decreased significantly.

Costs

Not available

Special Considerations

Please consider the following before selecting this strategy for your community:

- This program was a research project, not a package being disseminated or marketed.
- Some of the tools and methods can be adopted and used in other projects.

Contact Information

Please Note: This was a research project and is not a "product" being offered. The program developers request that only those persons who have read the research reports (see below) and who are seriously interested in replication contact the Gottfredsons.

For consultation, technical assistance or training, visit the following web site and click on Program Development and Evaluation:

http://www.gottfredson.com

To order a copy of the BASIS training materials manual (Cost: \$45) contact:

Ellen Czeh, Office Manager Gottfredson Associates, Inc. Behavioral Science Research and Development 3239 B Corporate Court Ellicott City, MD 21042

E-mail: ellenczeh@gottfredson.com

Phone: 410.461.5530 or

888.733.9805

Fax: 410.461.5529

See also:

Gottfredson, D.C., Gottfredson, G.D., and Hybl, L.G. (1993). Managing adolescent behavior: a multi-year, multi-school experiment. *American Educational Research Journal*, 30, 1, 179-216.

BEST PRACTICE: Project CARE

Description of Best Practice

(Excerpts from University of Maryland, College of Behavioral and Social Sciences, Department of Criminology and from the Criminal Justice "Program Fact Sheet.")

Project CARE is a school-wide intervention designed to address discipline practices through classroom management techniques and instructional innovation, such as cooperative learning and a career exploration program.

Project CARE was developed on the premise that bringing beneficial change to schools requires an organizational development approach to school change. This kind of an approach focuses attention on the school as an organization it examines the organizational culture and climate and seeks to improve the systems and procedures used by the organization. It usually focuses on:

- · Improving communication
- · Building trust and cooperation
- Enhancing the organization's problem-solving and decision-making capabilities
- · Strengthening its planning processes

A program development team of school- and district-level educators participated in a training for Program Development Evaluation (PDE) an organizational development method designed to help organizations initiate and sustain needed changes (Gottfredson, 1984; Gottfredson, Rickert, Gottfredson, and Advani, 1984). The team used this method to plan, implement, and refine an intervention that addressed both school-wide and classroom level instructional and discipline practices.

The intervention included these components:

- Two classroom management techniques—Assertiveness
 Discipline and Reality Therapy—used during seven lessons each semester (intended to promote a calm, orderly classroom atmosphere).
- Student Team Learning (STL) techniques, intended to change the classroom climate from a social to an academic one and to increase student motivation to master academic material, used for at least 6 lessons each semester (STL techniques provide incentives for students to learn academic material by establishing competitions for team reward or recognition).
- Frequent and consistent contact with parents about their child's classroom behavior.
- Parent volunteer program to increase involvement of parents in school activities.
- Community support program to increase community support and advocacy for the school.
- Extracurricular activities directed at increasing students' attachment to school, sense of school pride, and the ex-

tent to which they are rewarded for nonacademic talents.

- School discipline review and revision to establish a standard set of school rules, consequences for breaking school rules, and a disciplinary referral system to be used by all school staff members.
- Career exploration program to expose youth to positive role models in the community.

The program development team spent one school-year preparing for program implementation. Program developers trained participating teachers in both classroom management techniques.

Project CARE Goals

- · Clarify disciplinary procedures
- · Improve the consistency of rule enforcement
- Substitute positive reinforcement strategies for punitive strategies

Risk Factors Addressed

Antisocial behavior

Protective Factors Addressed

Healthy beliefs and clear standards Bonding: School

CSAP Strategy

Environmental

Type of Strategy

Universal

Populations Appropriate for This Best Practice

- · Junior high school students
- · African American

Evaluating This Best Practice

The following are suggested areas to assess when implementing this practice:

- Assess the level of teacher morale
- · Assess delinquency rate
- · Assess classroom orderliness

Research Conclusions

(Excerpts from University of Maryland, College of Behavioral and Social Sciences, Department of Criminology and the Criminal Justice "Program Fact Sheet.")

Project CARE was evaluated at two junior high schools selected by the central administrators of the Baltimore City Public School system. These schools were selected because they had experienced considerable disorder in the recent past, were believed to be in need of help, were expected to be receptive to the project, and were expected to remain stable in terms of their student, teacher, and administrator

populations over the following three years. Project CARE was implemented at one of the selected schools; the second school instead chose to develop a school improvement plan with minimal assistance from the researchers (and with minimal reliance on the PDE method).

Pretreatment measures of organizational health, school disorder, and student attitudes and experiences targeted by the program were compared with the same measures taken one and two years later. Change for both the treatment school and the quasi-comparison school were examined. All measures except for disciplinary removal from school were taken from surveys administered each year to all students and teachers in both schools.

There were no significant differences in student gender, age, or parental educational level between the two schools. Both school's student populations were virtually 100% Black. At the end of year 2, survey response rates for the two cohorts were also similar: 64.9% of the non-experimental cohort and 60.9% of then experimental cohort completed the survey.

Implementation of Project CARE produced the following effects:

- Improvements in organizational health: teacher morale rose from the 7th to the 40th percentile; teacher reports of innovation rose from the 38th to the 63rd, and teachers' perceptions of the school administration rose from the 3rd to the 31st percentile.
- · Reductions in delinquency.
- Increases in classroom orderliness.
- A reduction in student reports of rebellious behavior in the Project CARE school was observed (not statistically significant) while a significant increase was observed in the comparison school.

Costs

Not available

Special Considerations

Please consider the following before selecting this strategy for your community:

- · This program was a research project, not a package being disseminated or marketed.
- Some of the tools and methods can be adopted and used in other projects.

Contact Information

Please note: This was a research project and is not a "product" being offered. The program developers request that only those persons who have read the research reports and who are seriously interested in replication contact the Gottfredsons.

For consultation, technical assistance or training, visit the following web site and click on Program Development and **Evaluation:**

http://www.gottfredson.com

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BEST PRACTICE: Project Northland

(Perry)

Description of Best Practice

The goal of Project Northland is to prevent or reduce alcohol use among young adolescents by using a multilevel, community-wide approach. Conducted in 24 school districts in northeastern Minnesota since 1991, the intervention targets the class of 1998 (sixth-grade students in 1991).

The program consists of:

- · Social-behavioral curricula in schools
- · Peer leadership (designed to increase peer pressure resistance and social competence skills)
- Parental involvement/education (to provide parental support and modeling)
- · Community-wide task force activities (designed to change the larger environment)

Risk Factors Addressed

Friends who use Favorable attitudes toward drug use Early initiation of problem behavior Availability of drugs

Community laws and norms favorable toward drug use

Protective Factors Addressed

Bonding: School

Skills

Healthy beliefs and clear standards

CSAP Strategy

Information dissemination Education Alternatives Environmental

Type of Strategy

Universal

Populations Appropriate for This Best Practice

None specified

Evaluating This Best Practice

This best practice comes with an evaluation tool that can be used when implementing this strategy.

Evaluation Tool Cost:

\$0.65 per student surveyed plus \$1,000 - \$2,050 per standard report ordered. The student survey is a comprehensive prevention assessment tool. School-building and trend reports are available for \$250 to \$450.

The following are suggested areas to assess when implementing this practice:

- Assess decreased use of alcohol
- Assess changes in favorable attitudes toward drug use
- Assess social and behavioral skills gained
- Assess change in environmental restrictions regarding alcohol use (e.g. policies and laws)
- Assess change in perceived and actual alcohol use

Research Conclusions

The intervention group had lower rates of alcohol use and less reported tendency to use alcohol. Student's reported less perceived peer influence to use alcohol and knowing fewer peers who drink, increased self-efficacy to resist influences, and indicated more parent-child communication about

Costs as of December 2001 (Subject to Change)

Training Time:

There are two training options:

- · Open enrollment training is held for 3 days.
- · Contracted training can be held in the schools with the teachers, and is one day per grade level.

Training Costs:

Open enrollment training is \$755 and includes the 6 - 8 grade curriculum. The contracted training fee is \$1,750 plus travel expenses.

Strategy Implementation:

- · Training expenses
- \$755 for curriculum/materials for grades 6 8 plus the SUPERCHARGED! Community Component. This complete set includes materials for a classroom of 30 (includes teachers guides and student materials)
- \$155 for grade 6 workbooks
- \$62 for grade 6 prizes

Special Considerations

Please consider the following before selecting this strategy for your community:

- Prevention coordinators learn how to use the age-specific, multifaceted, interactive curriculum to help stop student drinking before it begins. They will find ways to integrate classroom activities, parent involvement, peer leadership, and community activities to consistently engage kids in prevention.
- There is a great level of parent and community involvement, so it is of great value to participate either in an open enrollment or contracted training where tools, tips, and techniques will be provided for getting the groups involved.

Contact Information

For more information on this program, visit web site:

http://modelprograms.samhsa.gov

To order the curriculum package contact:

Ann Standing

Hazelden

Box 176

15251 Pleasant Valley Road Center City, MN 55012-0176

E-mail: astanding@hazelden.org

Phone: 800.328.9000, press "1" then x 4030

Fax: 651.213.4577

Web site: http://www.hazelden.org

For training information contact:

Kaylene McElfresh (Open enrollment training)

Edie Julik (Contracted training)
E-mail: kmcelfresh@hazelden.org

E-mail: ejulik@hazelden.org

Phone: 800.328.9000, press "1" then x 4324

BEST PRACTICE: Project PATHE

(Organizational Change in School)

Description of Best Practice

(Excerpts reprinted with permission from the Center for the Study and Prevention of Violence, Institute of Behavioral Science, Regents of the University of Colorado, http://www.colorado.edu/cspv/blueprints/promise/PATHE.htm and from Gottfredson, Denise C. (1986). An empirical test of school-based environmental and individual interventions to reduce the risk of delinquent behavior. Criminology, 24, 705-731.)

Project PATHE is a comprehensive program implemented in secondary schools that reduces school disorder and improves the school environment to enhance students' experiences and attitudes about school.

The program has five major components:

- Staff, student, and community participation in revising school policies and designing and managing school change.
- School-wide organizational changes aimed at increasing academic performance.
- School-wide organizational changes aimed at enhancing school climate.
- 4. Programs to prepare students for careers.
- 5. Academic and affective services for high-risk youth.

The program design is unique in its comprehensive coverage and in its simultaneous focus on organizations and individual-level change. The program's success derives from its ability to effect school change in a number of ways:

- Staff, students, parents, and community members work together to design and implement improvement programs.
- School-wide academic weaknesses and discipline problems are diagnosed and strengthened through innovative teaching techniques and student team learning, as well as the development of clear, fair rules.
- The school climate is enhanced through adding job-seeking skills programs and career exploration programs.
- Career attainment is emphasized by adding job-seeking skills programs and career exploration programs.
- At-risk students receive additional monitoring, tutoring, and counseling aimed at improving their self-concept, academic success, and bonds to the social order.

Risk Factors Addressed

Lack of commitment to school Academic failure Antisocial behavior

Protective Factors Addressed

Healthy beliefs and clear standards Bonding to school

CSAP Strategy

Education Environmental

Type of Strategy

Universal and Selective

Populations Appropriate for This Best Practice

- · Middle/junior high schools and high schools
- African American
- Rural
- Low income

Evaluating This Best Practice

This best practice comes with an evaluation tool that can be used when implementing this strategy. Please call the contact below for cost, which includes assessment of schools with Effective School Battery. Implementers should also arrange to measure their own implementation and to provide frequent (e.g. monthly) implementation summaries.

The following are suggested areas to assess when implementing this practice:

- · Assess decrease in school suspensions
- · Assess decrease in delinquent behavior
- Assess decrease in drug use
- Assess change in school climate (safety, staff morale, and clarity of rules)

Research Conclusions

(Excerpts reprinted with permission from the Center for the Study and Prevention of Violence, Institute of Behavioral Science, Regents of the University of Colorado, http://www.colorado.edu/cspv/blueprints/promise/PATHE.htm)

Evaluations conducted after one year for high schools and two years for middle schools demonstrate significant improvement for PATHE schools, compared to control schools:

- Self-reported delinquency (serious delinquency, drug involvement, suspensions, and school punishments) declined for PATHE high schools, while it increased in the comparison school
- School alienation (individuals' sense of belonging) decreased in all treatment schools
- Attachment to school increased in the treatment middle schools, while decreasing in the comparison school
- School climate and discipline management improved in all the treatment schools

The PATHE program also showed positive effects for the atrisk students, compared to control students, including:

- · Higher rates of graduation for high school seniors
- Higher scores on standardized tests of achievement
- Increased school attendance

Costs as of May 2001 (Subject to Change)

Training Time:

- 4 days: 2 days initially for project director and on-site evaluator plus 2 days for all project staff.
- Periodic follow-up training over the life of the project.

Note: Training is required

Training Cost:

To be negotiated with persons listed on the web site:

www.gottfredson.com

Strategy Implementation Costs:

- · Project director
- · On-site evaluator
- · Full-time student concern specialist
- · Full-time academic achievement specialist
- · Outside evaluator or evaluation team
- Training for project director, on-site evaluator, and project staff

Special Considerations

Please consider the following before selecting this strategy for your community:

- This was a research project, not a program to be disseminated nor a product being offered to consumers.
- Replication would require very talented persons, including administrative, research, and organization development talent.
- Project PATHE is a comprehensive approach to restructuring education to improve achievement and student affective outcomes. It is a school change program, not a curriculum or packaged product that is simply "installed" in schools. Local educational leaders must invest heavily in a program development and evaluation process to design location-specific programs.

 Only persons who have read the research reports and who are seriously interested in replication should contact those individuals listed below.

Contact Information

Please note: This was a research project and is not a "product" being offered. The program developers request that only those persons who have read the research reports (see below) and who are seriously interested in replication contact the Gottfredsons.

Technical assistance and training is available by contracting with individuals listed on the web site:

http://www.gottfredson.com

For additional program information and materials ordering information (Program Development and Evaluation for Schools and Communities) web site:

http://www.gottfredson.com

or:

Denise Gottfredson, Ph.D. University of Maryland, LeFrak Hall College Park, MD 20742

E-mail: dgottfredson@crim.umd.edu

Phone: 301.405.4717 Fax: 301.405.4733

Additional references:

Gottfredson, Denise C. (1990). Changing school structures to benefit high-risk youths. *Understanding Troubled and Troubling Youth: Multidisciplinary Perspectives.* Newbury Park, CA: Sage.

Gottfredson, Denise C. (1986). An empirical test of school-based environmental and individual interventions to reduce the risk of delinquent behavior. *Criminology*, 24, 705-731. (Article can be ordered at http://www.gottfredson.com)

BEST PRACTICE: Project STAR

(Pentz et al)

Description of Best Practice

Please Note: This practice is not commercially available right now. The developers of Project STAR are currently developing a Training of Trainers in order to create an infrastructure to widely disseminate this program. Consequently, training and technical assistance on this project are not currently available.

(Excerpts from Drug Abuse Prevention: What Works, National Institute on Drug Abuse, 1997, pp. 47-50.)

The Midwestern Prevention Project, Project STAR (Students Taught Awareness and Resistance, Pentz et al. 1989, 1990) is a community-wide, multi-component universal substance abuse prevention program for students in early adolescence, in grades seven and eight.

Project STAR, which uses the school, family, and broader community environments as the launch sites for prevention programming, began in 1984 in Kansas City, Missouri and was later replicated in Indianapolis, Indiana. The Kansas City program is referred to as Project STAR and the Indianapolis program as Project I-STAR. Unless otherwise specified, the term Project STAR refers to both programs.

This research-based, universal prevention program has the following five elements:

- · A school-based program
- · Mass media programming
- A parent program
- · Community organization
- · Health policy change

Project STAR is a universal prevention program because an entire community receives the prevention messages through the media, and all the residents benefit from the community organization and health policy changes. All of the children in the designated grades receive the school program and their families receive the parent program without regard to their individual risk status or their membership in an at-risk subgroup.

The five elements of Project STAR are designed to be implemented in the sequence given:

- The school-based program and mass media programming are implemented concurrently
- 2) The media component continues throughout the project

These are followed by:

- 3) The parent program
- 4) Community organization
- 5) The health policy change component

Some overlap occurs in the implementation of all these elements. This sequencing is recommended to increase the visibility and support and, ultimately, the impact of the project at all levels within the community. Each element is briefly described in the following paragraphs.

School-Based Program

The core of the school-based program is a social influence curriculum that is integrated into classroom instruction by trained teachers over a two-year period. Each of the lessons takes approximately 45 minutes of class time to complete.

- During the first year, a 13-lesson core curriculum is taught, followed by a five-lesson booster curriculum in the second year.
- Classroom work is supplemented by homework that is completed by both students and parents.
- Teachers are given an intensive three-day training (two days for the basic curriculum, one day for the booster curriculum) during which they learn the Project STAR teaching methods and strategies to encourage homework participation. This educational component focuses on increasing students' resistance skills.

In the process, an anti-drug climate is established throughout the school and community. This is accomplished through other interrelated facets of the school program, specifically, the active support of the school administration–principals and school district personnel–and student skill leaders who serve as role models for various aspects of skill development.

Mass Media Programming

Mass media programming is used to introduce, promote, and reinforce the implementation and maintenance of Project STAR. The media component, which begins at the same time as the school component and continues throughout Project STAR, is designed to provide the most effective means to disseminate the prevention message throughout the community. It also increases exposure of the project and relevant substance abuse issues.

Representatives from the media initially are encouraged to attend a two-hour overview session conducted by program staff. A media representative is then encouraged to participate formally in the community organization component of the program. Contact is maintained with the print, television, and radio media through press releases and other public relations strategies. Program staff work with advertising agencies and communications or public relations departments in businesses or universities to develop the content for public service announcements and educational or training tapes.

Parent Program

The parent program involves parents in several ways to increase student participation and expand the educational reach of the project:

- Parents are encouraged to participate in the school component by working with their children on homework assignments that they are required to complete together.
- Parents are encouraged to participate in a school-based parent organization that organizes initiatives and activities that limit youths' accessibility to substances, supports

fundraising efforts, and backs local school policies on substances.

 The parents are also given training opportunities that help develop effective communication, substance use resistance skills, and other techniques that support their children's substance-free behaviors.

This parent skill training program consists of two 2-hour sessions conducted at the school site. Parents are encouraged to participate in the community organization component of Project STAR.

Community Organization

Community organization is the glue that holds Project STAR together. It is a formal organization designed to develop support for Project STAR among volunteers and leaders from all sectors of the community and to oversee the implementation and maintenance of the program.

Community organization involves local leaders who work to ensure the integrity of the project, provide direction regarding the development of health policies concerning illicit drugs, help maintain community-wide support for substance abuse prevention, develop community campaigns to complement other program components, and help identify sources of consistent funding.

Health Policy Change

The health policy change component of Project STAR is the mechanism used to develop and implement local health policies that affect drug, alcohol, and tobacco laws. Policy development is one of the tasks of community organization.

Policy changes can include:

- · Monitoring drug-free school zones
- Setting policies for drug-free workplaces
- · Restricting smoking in public places
- Establishing guidelines for teacher referral of students to substance abuse counseling programs

Risk Factors Addressed

Availability of drugs Community laws and norms Friends who use Favorable attitudes toward drug use

Protective Factors Addressed

Bonding: Family Healthy beliefs and clear standards

CSAP Strategy

Information dissemination Community-based process Environmental

Type of Strategy

Universal

Populations Appropriate for This Best Practice

- · Middle school youth
- Parents
- · Community at large

Evaluating This Best Practice

The following are suggested areas to assess when implementing this practice:

- Determine the number and type of policies that related to the taxation of alcohol and tobacco.
- Determine decrease in alcohol, tobacco, and marijuana use by youth.
- Assess increased perceptions of friends' intolerance of drug use.

Costs and Special Considerations

Not currently available

Research Conclusions

The results of extensive evaluations in Kansas City and Indianapolis indicate that Project STAR is an effective multicomponent, community-wide universal prevention strategy for reducing youth substance abuse and changing students' attitudes toward drug and alcohol abuse. Specifically, the Kansas City project results showed a significant decrease in alcohol, tobacco, and marijuana use among the students who participated in the project one year following their participation. This decrease in tobacco, alcohol, and marijuana abuse was maintained for more than three years after program participation.

Similar results from the Indianapolis project showed that students who participated in the program were less likely to smoke marijuana, drink alcohol, and abuse illegal drugs than students who did not participate in the program. The overall effectiveness of the Midwestern Prevention Project is discussed in greater detail in Drug Abuse Prevention for the General Population (by NIDA, 1997 – see below).

Contact Information

Please Note: This practice is not commercially available right now. The developers of Project STAR are currently developing a Training of Trainers in order to create an infrastructure to widely disseminate this program. Consequently, training and technical assistance on this project are not currently available.

For more information on this program, visit web site:

http://modelprograms.samhsa.gov

(Excerpt from *Drug Abuse Prevention: What Works,* National Institute on Drug Abuse, 1997, p. 50.)

For general inquiries, contact:

Karen Bernstein, MPH Project Manager University of Southern California Institute for Prevention Research 1000 S. Fremont Ave., Unit #8 Alhambra, CA 91803

E-mail: karenber@usc.edu Phone: 626 457.6687 Fax: 626.457.6695

The resource "Blueprint" offers step-by-step instructions that help communities plan and implement youth crime and vio-

lence prevention strategies. For a summary copy of this program, cost \$10 per copy, contact:

Web site:

http://www.Colorado.EDU/cspv/blueprints/model/index.html

or

http://www.colorado.edu/cspv/blueprints

Center for the Study and Prevention of Violence Institute of Behavioral Science University of Colorado at Boulder Campus Box 442 Boulder, CO 80309-0442

Phone: 303.492.8465

For a copy of the source of this page: *Drug Abuse Prevention* for the General Population by National Institute on Drug Abuse (1997) publication number PB# 98-113095, May 2001. Cost (subject to change): \$36 plus \$5 handling, contact: National Technical Information Services at 800.553.6847.

For a copy of the *Drug Abuse Prevention Package: Drug Abuse Prevention: What works; Community Readiness for Drug Abuse Prevention; Issues, Tips, and Tools; Drug Abuse Prevention and Community Readiness: Training Facilitators Manual,* 1997, by National Institute on Drug Abuse, publication number PB# 97-209605, also contact: National Technical Information Services. Packet costs as of May 2001 (subject to change): \$83 plus \$5 handling.

BEST PRACTICE: Project STATUS

Description of Best Practice

(Excerpt reprinted with permission from the Center for the Study and Prevention of Violence, Institute of Behavioral Science, Regents of the University of Colorado, http://www.Colorado.EDU/cspv/blueprints/promise/status.htm)

Project STATUS (Student Training Through Urban Strategies) is a school-based program that helps students become active, responsible members of their community. Based on the belief that isolating students in book-learning environments fails to inspire commitment to schools and belief in social rules, the Project provides a more challenging and relevant educational experience. It increases students' pro-social behaviors by providing contact with positive adult role models, enhancing stakes in conformity, and altering peer relationships.

The Project STATUS program combats youths' anti-social behavior through two main strategies: improving the school's climate and implementing a year-long English/Social Studies class that focuses on key social institutions. The school climate intervention allows students, school personnel, parents, and community members to work together for change, and is comprised of four components:

- 1. A youth committee/leadership training class in which students identify and help solve school problems
- 2. Staff development training to improve student discipline procedures and increase positive and supportive interactions between staff and students
- 3. Action committees in which citizens make community resources available to students and serve as positive role
- 4. Parent meetings that allow parents to contribute to school decision-making and improves awareness of their children's educational activities

Junior and senior high school students, and students at-risk for dropping out of school targeted for the options class. The options class increases the relevance of in-school learning to life experiences by educating students about social institutions.

The junior high program focuses on:

- the school (its rules and their enforcement, and students' rights and responsibilities)
- · human nature, interpersonal relationships, and norms for behavior; the family; social contracts and their contributions to the social order; and
- the criminal justice system (including its justice, fairness, and equity)

The high school curriculum substitutes job market and life planning skills for the human nature and family units.

All classes emphasize active student involvement and include field trips, guest speakers, role playing, and independent and group research. These activities promote:

- · Students' understanding of society and its systems of laws
- Emphasize critical thinking and problem-solving skills
- Increase academic success

Risk Factors Addressed

Persistent antisocial behavior Friends involved in the problem behavior Low commitment to school

Protective Factors Addressed

Bonding: School

CSAP Strategy

Educational Environmental

Type of Strategy

Selective

Populations Appropriate for This Best Practice

Junior and senior high school students at-risk for dropping out of school

Evaluating This Best Practice

The following are suggested areas to assess when implementing this practice:

- · Assess delinquency rate of participants
- · Assess level of drug use
- Assess level of negative peer influence
- Assess academic success of participants
- Assess level of attachment to school

Research Conclusions

(Excerpt reprinted with permission from the Center for the Study and Prevention of Violence, Institute of Behavioral Science, Regents of the University of Colorado, http://www.Colorado.EDU/cspv/blueprints/promise/status.htm)

An evaluation of Project STATUS showed significant beneficial effects for intervention students, compared to control students, including the following:

- · Less total delinquency for all students and less serious delinquency for high school students
- · Less drug involvement for junior high students
- · Less negative peer influence
- · Greater academic success, including higher grades and perceptions of schools as less punishing
- · Greater social bonding, including greater attachment to

school for junior high students, and increased self-concept, attachment to school, interpersonal competency, involvement, months on roll, and less alienation for high school students

Costs and Special Considerations

Not currently available

Contact Information

A research article only is available from: Denise Gottfredson 2220D LeFrak Hall College Park, MD 20742

E-mail: dgottfredson@crim.umd.edu

Phone: 301.405.4717

BEST PRACTICE: Project Towards No Drug Abuse

Description of Best Practice

(Excerpts taken from: http://modelprograms.samhsa.gov and from materials provided by Steve Sussman.)

Project Towards No Drug Abuse (TND) includes 12 classroom-based lessons, approximately 40 to 50 minutes each, designed to be implemented over a four-week period, although they could be spread out over as long as five weeks on the condition that all lessons are taught. The instruction to students provides detailed information about the social and health consequences of drug use, and addresses topics including instruction in active listening, effective communication skills, stress management, tobacco cessation techniques, and self-control to counteract risk factors for drug abuse relevant to older teens.

The theory underlying Project TND is that young people at risk for drug abuse will be best able to not use drugs if they:

- 1. Are aware of misleading information that facilitates drug use and are motivated to not use drugs (e.g., drug-use myths, stereotyping)
- 2. Have skills to help them bond to lower risk contexts (e.g., coping, self-control)
- 3. Appreciate the consequences that drug use may have on their own and others' lives (e.g., chemical dependency)
- 4. Are aware of cessation strategies
- 5. Have decision-making skills to make a commitment to not abuse drugs

Risk Factors Addressed

Favorable attitudes toward use

Protective Factors Addressed

Skills

CSAP Strategy

Education

Type of Strategy

Selective Indicated

Populations Appropriate for This Best Practice

- · High school youth at high risk for drug abuse
- · Alternative high school students
- Caucasian youth
- · Latino youth
- · African American youth
- · Asian American youth

Evaluating This Best Practice

This best practice comes with an immediate post-test evaluation tool that can be used when implementing this strategy, upon request.

Evaluation Tool Cost: \$2.50

The following suggestion is an area you may want to assess if you implement this best practice:

Assess the prevalence of use by participants in the fol $lowing\ areas:\ 30\text{-}day\ cigarette\ use,\ 30\text{-}day\ marijuana\ use,}$ 30-day "hard drug" use, 30-day alcohol use, and 1-year weapons carrying.

Research Conclusions

(Excerpt from materials provided by Steve Sussman)

At one-year follow-up relative to comparisons, participants experienced:

- 27% prevalence reduction in 30-day cigarette use
- 22% prevalence reduction in 30-day marijuana use
- · 26% prevalence reduction in 30-day hard drug use
- 9% prevalence reduction in 30-day alcohol use among baseline drinkers
- 25% prevalence reduction in 1-year weapons carrying among males

Note: Prevalence reduction refers to no engagement in a behavior within the time period specified (i.e., the last 30 days, the last year)

Costs as of December 2001 (Subject to Change)

Training Time: 2 days

Training Cost:

\$400 per day for trainer/consultant \$190 for support staff preparation work Plus travel and incidental expenses

Materials Cost:

Teacher's Manual: \$70

Student Workbook (set of 5): \$50 Video: "Drugs and Life's Dreams," \$40

Articles: \$2.50 each

Special Considerations

Please consider the following before selecting this strategy for your community:

- Delivering 12 lessons, each 40 to 50 minutes in duration. An earlier model involved delivery of 9 lessons, whereas the current Project TND model involved the addition of 3 more lessons (to target marijuana use and cigarette smoking). This current model is designed to be delivered during a 4-week period, although lessons could be spread over 6 weeks on the condition that all lessons are taught.
- To be successful, the program should be teacher led and classroom based. Neither the use of a school-as-community component, nor use of a self-instruction version of these lessons, contributes to the effectiveness of the program.

- Many states are able to provide information and technical assistance on this curriculum. For inquiries, call the tobacco prevention coordinator at your state department of education or your state department of health.
- Local Boards of Education usually provide certificates and/or continuing education.

Contact Information

For information on training and materials, contact:

France Deas, Administrative Assistant Institute for Health Promotion and Disease Prevention Research

University of Southern California 1000 South Fremont Avenue, Unit #8 Alhambra, CA 91803

E-mail: deas@hsc.usc.edu Phone: 626.457.6634

Fax: 626 457.4012 or 5856

For research questions, contact:

http://www.cceanet.org/Research/Sussman/tnd.htm

Steve Sussman, Ph.D., Principal Investigator Institute for Health Promotion and Disease Prevention Research

University of Southern California 1000 South Fremont Avenue, Unit #8 Alhambra, CA 91803

E-mail: ssussma@hsc.usc.edu

Phone: 626 457.6635

Fax: 626.457.4012 or 5856

BEST PRACTICE: Project Towards No Tobacco Use

Description of Best Practice

The theory underlying Project TNT is that young people will be best able to resist using tobacco products if they:

- 1. Are aware of misleading social information that facilitates tobacco use (e.g. advertising, inflating prevalence estimates)
- 2. Have skills that counteract the social pressures to achieve approval by using tobacco
- 3. Appreciate the physical consequences that tobacco use may have on their own lives (e.g., the beginnings of addiction).

Project TNT is designed to counteract different causes of tobacco use simultaneously because the behavior is determined by multiple causes. This comprehensive approach is well suited to a wide variety of youth who may differ in risk factors that influence their tobacco use.

Ten core lessons and two booster lessons, each 40 to 50 minutes. The ten core lessons are designed to occur during a two-week period, although they could be spread over four weeks on the condition that all lessons are taught. The twolesson booster was developed to be taught one year after the core lessons in a two-day sequence. However, these could be taught one lesson per week.

Objectives

At the completion of the program, students will be able to:

- Describe the course of tobacco addiction and disease, the consequences of using tobacco, and the prevalence of tobacco use among peers
- Demonstrate effective communication, refusal, and cognitive coping skills
- · Identify how the media and advertisers influence teens to use tobacco products
- · Identify methods for building their own self-esteem
- · Describe strategies for advocating no tobacco use

Strategy Implementation

The implementation teacher's manual provides step-by-step instructions for completing each of the 10 core lessons and two booster lessons, together with introductory and background material. Two videos are also included to support the curriculum. The first, Stand Up for Yourself, emphasizes assertive and refusal skills and is produced specifically and produced by Churchill Media in both English and Spanish specifically to support Session Seven of the curriculum. The second, Tobacco Use Social Images, is designed to combat tobacco use-specific social images to support Session Eight of the curriculum.

Risk Factors Addressed

Early initiation of the problem behavior

Protective Factors Addressed

Skills:

Communication Refusal Cognitive Coping

CSAP Strategy

Information dissemination Education

Type of Strategy

Universal

Populations Appropriate for This Best Practice

- Students in grade 7
- White non-Hispanic
- Latino
- African American
- Asian American

Evaluating This Best Practice

This best practice comes with a pre-test/post-test evaluation tool and health educator rating tools that can be used when implementing this strategy.

Evaluation Tool Cost: \$2.50

The following are suggested areas to assess when implementing this practice:

- · Assess reduction in initiation of cigarettes and smokeless tobacco
- · Assess acquisition of communication skills, refusal skills, and cognitive coping skills
- · Assess frequency of cigarette and smokeless tobacco use

Research Conclusions

Behavioral Findings

- · Students in Project TNT reduced initiation of cigarettes by approximately 26% over the control group, when oneyear and two-year follow-up outcomes were averaged together.
- Students in Project TNT reduced initiation of smokeless tobacco use by approximately 30%.
- Weekly or more frequent cigarette smoking by students in the Project TNT group was reduced by approximately
- For students in the Project TNT group, weekly or more frequent smokeless tobacco use was eliminated.

Costs as of December 2001 (Subject to Change)

Training Time: 2 days

Training Costs:

- \$400 per day for trainer/consultant
- \$190 for support staff preparation work
- · Plus travel and incidental expenses

Strategy Implementation:

- \$45 (plus shipping and handling) for implementation teacher's manual
- \$18.95 (plus shipping and handling) for a set of five student workbooks
- \$40 for the video, "Tobacco Use Social Images"
- \$79.95 for the video, "Stand Up For Yourself"
- \$40 each for the TNT Cessation Program
- · \$2.50 each for 3 research articles

The implementation teacher's manual provides step-by-step instructions for completing each of the 10 core lessons and two booster lessons, together with introductory and background material.

The "Tobacco Use Social Images" video is designed to combat tobacco use-specific social images and produced by Churchill Media in both English and Spanish specifically to support Session Seven of the curriculum.

The "Stand Up For Yourself" video emphasizes assertive and refusal skills and is produced specifically to support Session Eight of the curriculum.

Special Considerations

Please consider the following before selecting this strategy for your community:

- Many states are able to provide information and technical assistance on this curriculum. For inquiries, call the tobacco prevention coordinator at your state department of education or your state department of health.
- Local Boards of Education usually provide certificates and/or continuing education.

Contact Information

For more information on this program, visit web site:

http://modelprograms.samhsa.gov

For information on training, videos and ancillary materials, contact:

France Deas, Administrative Assistant

Institute for Health Promotion and Disease Prevention Research

University of Southern California

1000 South Fremont Avenue, Unit #8

Alhambra, CA 91803

E-mail: deas@hsc.usc.edu Phone: 626.457.6634

Fax: 626.457.4012 or 5856

For research questions, contact:

http://www.cceanet.org/Research/Sussman/tnd.htm

Steve Sussman, Ph.D., Principal Investigator

Institute for Health Promotion and Disease Prevention

Research

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Alhambra, CA 91803

E-mail: sussma@hsc.usc.edu

Phone: 626.457.6635

Fax: 626.457.4012 or 5856

To order the teacher's manual and workbooks, and for shipping and handling rates, contact:

Web site: http://www.etr.org

(print catalogues can also be requested on-line)

ETR Associates P. O. Box 1830

Santa Cruz, CA 95061-1830

Customer Service Phone:

800.321.4407, 6:30 AM to 5:00 PM PST

Phone: 800.321.4407 Fax: 800.435.8433

BEST PRACTICE: Promoting Alternative Thinking Strategies

Description of Best Practice

(Excerpt reprinted with permission from the Center for the Study and Prevention of Violence, Institute of Behavioral Science, Regents of the University of Colorado, http://www.Colorado.EDU/cspv/blueprints/model/ten_paths.htm)

The PATHS (Promoting Alternative Thinking Strategies) Curriculum is a comprehensive program for promoting emotional and social competencies and reducing aggression and behavior problems in elementary school-aged children while simultaneously enhancing the educational process in the classroom. This innovative curriculum is designed to be used by educators and counselors in a multi-year, universal prevention model. Although primarily focused on the school and classroom settings, information and activities are also included for use with parents.

The PATHS Curriculum was developed for use in the classroom setting with all elementary school aged-children. PATHS has been field-tested and researched with children in regular education classroom settings, as well as with a variety of special needs students (deaf, hearing-impaired, learning disabled, emotionally disturbed, mildly mentally delayed, and gifted). Ideally, it should be initiated at the entrance to schooling and continue through Grade 5.

The PATHS Curriculum, taught three times per week for a minimum of 20-30 minutes per day, provides teachers with systematic, developmentally-based lessons, materials, and instructions for teaching their students:

- · Emotional literacy
- Self-control
- Social competence
- · Positive peer relations
- · Interpersonal problem-solving skills

A key objective of promoting these developmental skills is to prevent or reduce behavioral and emotional problems.

PATHS lessons include instruction in:

- · Identifying and labeling feelings
- · Expressing feelings
- Assessing the intensity of feelings
- Managing feelings
- Understanding the difference between feelings and behaviors
- · Delaying gratification
- Controlling impulses
- · Reducing stress
- Self-talk
- Reading and interpreting social cues
- Understanding the perspectives of others
- Using steps for problem-solving and decision-making
- Having a positive attitude toward life
- **Self-awareness**
- Nonverbal communication skills
- Verbal communication skills

Teachers receive training in a two- to three-day workshop and in bi-weekly meetings with the curriculum consultant.

Risk Factors Addressed

Early antisocial behavior

Protective Factors Addressed

Skills: Emotional and social competence

CSAP Strategy

Education

Type of Strategy

Universal

Populations Appropriate for This Best Practice

- · Elementary school-aged children
- Special needs students (deaf, hearing-impaired, learning disabled, emotionally disturbed, mildly mentally delayed, and gifted)
- Caucasian
- African American

Evaluating This Best Practice

This best practice does not come with an evaluation tool for implementing this strategy.

The following are suggested areas to assess when implementing this practice:

- Assess conduct problems (through teacher reports)
- Assess use of effective conflict-resolution strategies
- Assess improved thinking and planning skills
- Assess ability to tolerate frustration
- Assess self-control

Research Conclusions

(Excerpt reprinted with permission from the Center for the Study and Prevention of Violence, Institute of Behavioral Science, Regents of the University of Colorado, http://www.Colorado.EDU/cspv/blueprints/model/ten_paths.htm)

The PATHS Curriculum has been shown to improve protective factors and reduce behavioral risk factors. Evaluations have demonstrated significant improvements for program youth (regular education, special needs, and deaf) compared to control youth in the following areas:

- · Improved self-control
- · Improved understanding and recognition of emotions
- · Increased ability to tolerate frustration
- Use of more effective conflict-resolution strategies
- Improved thinking and planning skills
- Decreased anxiety/depressive symptoms (teacher report of special needs students)
- Decreased conduct problems (teacher report of special needs students)

- Decreased symptoms of sadness and depression (child report – special needs)
- Decreased report of conduct problems, including aggression (child report)

Costs as of December 2001 (Subject to Change)

Training Time: Three days

Training Cost:

To be discussed with the contact listed below

 $\it Strategy Implementation: $640 plus shipping for the curriculum kit.$

This figure includes the following:

- One instructor's manual
- · Five curriculum manuals
- One Turtle unit manual
- · Additional curriculum materials (posters, puppets, etc.)

Note: Program costs over a three-year period would range from \$15/student/year to \$45/student/year. The higher cost would include hiring an on-site coordinator, the lower cost would include redeploying current staff.

Special Considerations

Please consider the following before selecting this strategy for your community:

• This program is an elementary school-based program.

Contact Information

For general information, contact:

Sarah Clay

Channing Bete Company

One Community Place

South Deerfield, MA 01373-0200

E-mail: sclay@channing-bete.com

Phone: 800.828.2827 Fax: 413.665.7117

Web site: www.channing-bete.com

For training and materials, contact:

Beth Huanca

Channing Bete Company

One Community Place

South Deerfield, MA 01373-0200

E-mail: bhuanca@channing-bete.com

Phone: 800.828.2827 Fax: 800.329.2939

For technical assistance, contact:

Mark Greenberg, Ph.D. Prevention Research Center Henderson Building South Pennsylvania State University University Park, PA 16802

E-mail: mxg47@psu.edu Phone: 814.863.0112 Fax: 814.865.2530

For a copy of a summary of the "Blueprint" (step-by-step instructions that will help communities plan and implement youth crime and violence prevention strategies) for this program (Cost: \$15 per copy) visit web site:

http://www.colorado.edu/cspv/blueprints

or contact:

Center for the Study and Prevention of Violence

Institute of Behavioral Science University of Colorado at Boulder

Campus Box 442

Boulder, CO 80309-0442 Phone: 303 492.8465

BEST PRACTICE: Quantum Opportunities Program

Description of Best Practice

(Excerpts from: The Quantum Opportunities Program, 1998, In Blueprints for Violence Prevention [Book 4] Center for the Study and Prevention of Violence, Institute of Behavioral Science, University of Colorado)

Quantum Opportunities Program (QOP) is a four-year, year round program that provides a balanced sequence of education opportunities, development opportunities, and service opportunities to small groups of youth from families receiving public assistance. The participants (called "Associates") from grade nine through high school graduation, are given an opportunity to receive annually:

- 250 hours of education activities: computer-assisted instruction, peer tutoring, etc., to enhance basic academic skills
- · 250 hours of development activities: cultural and development activities, acquiring life/family skills, planning for college and advanced training, and job preparation
- · 250 hours of service activities: community service projects, helping with public events, and working as a volunteer in various agencies

Everyone involved in QOP shares in performance-based incentives. Modest cash and scholarship incentives are offered to participants to provide short-term motivation. Incentives are also provided for staff and agencies based on student participation hours. The program is coordinated by a caring adult who serves as a mentor, role model, disciplinarian, broker, and problem solver.

Although the development of QOP was not based on any particular theoretical model, the rationale underlying QOP principles most closely resembles assumptions found in the Social Development Model (Catalano and Hawkins, 1996). Briefly, this theory states that four prerequisites are necessary for successful youth development:

- 1. Perceived opportunities for involvement in activities and interactions with others
- 2. A degree of involvement and interaction
- 3. The skills to participate in these involvements and inter-
- 4. The reinforcement they perceive as forthcoming from performance in activities and interactions

These four processes, when consistent, act to create a social bond between the individual and the socializing unit, which has the power to affect behavior independently of the four social learning processes. When a strong social bond develops, individuals develop a stake in conforming to the norms and values of the socializing unit. The social bond that develops consists of attachment and commitment to the socializing unit, and belief in its values.

Utilizing the four processes described above, the QOP framework strives to compensate for some of the deficits found in poverty areas, by:

- · Compensating for both the perceived and real lack of opportunities, which are characteristic of disadvantaged neighborhoods (e.g., QOP instills the belief that success and upward mobility is attainable; it helps youth to overcome the negative and formulate goals and work toward their achievement)
- Providing interactions and involvement with persons who hold pro-social values and beliefs (e.g., QOP strives for a caring and enduring relationship between each Associate and Coordinator; the Coordinator becomes surrogate parent, role model, advisor, and disciplinarian)
- Enhancing the skill levels (academic and functional) of Associates to equip them for success (e.g., education, development activities, and service activities)
- Reinforcing positive achievements and actions (e.g., instructors, instructional approaches and instructional materials provide frequent feedback and positive reinforcement which recognize both individual effort and achievement)

Risk Factors Addressed

Extreme economic deprivation Academic failure

Protective Factors Addressed

Healthy beliefs and clear standards Opportunities, skills, and recognition School bonding

CSAP Strategy

Education Alternatives

Type of Strategy

Selective

Populations Appropriate for This Best Practice

- · Economically disadvantaged
- · 9th grade through graduation from high school

Evaluating This Best Practice

The following are suggested areas to assess when implementing this practice:

- · Assess graduation rates of participants
- Assess number of participants who go on to attend postsecondary school

Research Conclusions

An evaluation of the Quantum Opportunities Program was conducted throughout the years that QOP participants and a control group were in high school, with a follow-up one year after QOP ended. Results indicate that:

- QOP participants had more positive outcomes in terms of educational attainment and social achievement
- In the year following the end of QOP, Associates were more likely than control group members to have graduated from high school and to be attending a post-secondary school
- One year after QOP ended, the proportion of QOP participants receiving honors or awards was nearly three times higher than the control group, and the proportion of individuals who had performed some sort of community service was higher
- QOP participants were less likely to be arrested during the juvenile years and they also had fewer children than the control group

Costs and Special Considerations

Please inquire of the contact below.

Contact Information

For more information contact:

C. Benjamin Lattimore or Deborah L. Scott Opportunities Industrialization Centers of America 1415 North Broad Street Philadelphia, PA 19122

E-mail: CBEL2@aol.com for Benjamin, and

DScott7955@aol.com for Deborah

Phone: 215.236.4500 Fax: 215.236.7480

For a copy of a summary of the "Blueprint" (step-by-step instructions that will help communities plan and implement youth crime and violence prevention strategies) for this program, visit:

http://www.colorado.edu/cspv/blueprints

Center for the Study and Prevention of Violence Institute of Behavioral Science University of Colorado at Boulder Campus Box 442

Boulder, CO 80309-0442 Phone: 303.492.8465

BEST PRACTICE: Raising a Thinking Child: I Can Problem Solve (ICPS) Program for Families

Description of Best Practice

(Excerpt from Strengthening America's Families' web site http://www.strengtheningfamilies.org/index.html)

The focus of this program is on developing a set of interpersonal cognitive problem solving (ICPS) skills that relate to overt behaviors as early as preschool. By enhancing ICPS skills, the ultimate goal is to increase the probability of preventing later, more serious problems by addressing the behavioral predictors early in life.

In addition to behavioral outcomes, the parent intervention is designed to help parents use a problem-solving style of communication that guides young children to think for themselves. The program was originally designed for mothers or legal guardians of African American, low-income four yearolds. The program now includes parents of children up to age seven and has been expanded to include middle and upper-middle income populations in the normal behavioral range as well as those displaying early high-risk behaviors. These include those diagnosed with Attention Deficit Hyperactivity Disorder and other special needs.

The program takes ten to twelve weekly sessions to complete, although a minimum of six weeks is sufficient to convey the approach.

- · The first section focuses on learning a problem-solving vocabulary in the form of games.
- The second section concentrates on teaching children how to listen. It also teaches them how to identify their own and other's feelings, and to realize that people can feel different ways about the same thing.
- · In the last section children are given hypothetical problems and are asked to think about people's feelings, consequences to their acts, and different ways to solve problems.

During the program, parents are given exercises to help them think about their own feelings and become sensitive to those of their children. Parents also learn how to find out their child's view of the problem and how to engage their child in the process of problem solving.

Risk Factors Addressed

Early antisocial behaviors

Protective Factors Addressed

Interpersonal Problem Solving Skills

CSAP Strategy

Education

Type of Strategy

Universal

Populations Appropriate for This Best Practice

- Children 4-7 years old and their parents
- · Low income African American families
- Middle and upper middle income Caucasian families
- Children with Attention Deficit Hyperactivity Disorder

Evaluating This Best Practice

This best practice comes with evaluation tools that can be used when implementing this strategy.

Evaluation Tool Cost: \$38.50.

This figure includes the following options:

Preschool Interpersonal Problem Solving (PIPS) test, \$17.50

What Happens Next Game (WHNG) \$8.50

Behavior Rating Scale, \$5.00

Child Rearing Style Interview, \$7.50

Each tool above is separate and optional.

The following are suggested areas to assess when implementing this practice:

- Assess increase in interpersonal problem solving skills, including an increase in alternative solution thinking and consequential thinking
- · Assess decrease in early antisocial behavior

Research Conclusions

(Excerpt from Strengthening America's Families' web site http://www.strengtheningfamilies.org/index.html)

Among low-income African American mothers, one pilot and two hypothesis-testing studies were done with their four year-olds, and a three year follow-up with mothers and their six to seven year-olds. Among middle and upper middleincome Caucasian families, two qualitative service evaluations by staff of mental health associations were conducted.

With over 100 families participating in the research and evaluations, relatively normal children with varying degrees of high-risk behaviors, as well as those with ADHD, significantly improved in:

- · Alternative solution thinking
- Consequential thinking
- · High-risk behaviors both in school and at home

Costs as of December 2001 (Subject to Change)

One-half day or one full day; two day trainings are also available

Training Costs:

• \$1,000 per day plus travel and expenses for any number of participants. (However, training costs are negotiable, as needed.)

- \$19.95 per trainer and per parent (of children ages 4 to 7) for parent training workbook. Training materials are also available for 8 to 12 year-olds.
- Optional: \$13 per parent trainer for Raising A Thinking Child book

Note: Trainers come on-site, present a program overview, role-play lesson implementation, and role-play how to talk with children using the problem solving style. Training can be a train-the-trainers model or training parents directly. Training can be combined with the school curricula, I Can Problem Solve, or stand-alone for parent educators and/or parents.

Special Considerations

Please consider the following before selecting this strategy for your community:

- Parents need at least a fourth grade reading level to read the questions in the workbook to their children.
- Older children can also "play teacher" and read the questions to younger children as well.
- Parents unable to read can be taken through the pages for parents (the ICPS ladder) orally in group meetings.

Contact Information

To order the Raising a Thinking Child Workbook published by Research Press and currently available for \$19.95 (plus S & H) contact:

Web site: http://researchpress.com

or:

Toll free: 800.519.2707

One manual is needed per parent.

To order the book *Raising a Thinking Child*, published by Pocketbooks for \$13, visit your local bookstore or, to order in quantities, call 212.698.2105. One book is needed for each parent trainer, but parents can learn the approach with the above-mentioned workbook only.

Note: For school curriculum see the I Can Problem Solve program.

For more information on training, materials and the evaluation of this program, contact:

Myrna Shure, Ph.D. MCP Hahnemann University 245 North 15th Street, MS 626 Philadelphia, PA 19102-1192

E-mail: mshure@drexel.edu

Phone: 215.762.7205 Fax: 215.762.8625

BEST PRACTICE: Raising the Minimum Legal Drinking Age

Description of Best Practice

(Excerpt from Alcohol Alert, National Institute on Alcohol Abuse and Alcoholism, October 1996, No. 34, p. 1, PH 370.)

Minimum Legal Drinking Age (MLDA) legislation is intended to reduce alcohol use among those under 21, to prevent traffic deaths, and to avoid other negative outcomes.

Risk Factors Addressed

Community laws and norms favorable toward drug use

Protective Factors Addressed

Healthy beliefs and clear standards

CSAP Strategy

Environmental

Type of Strategy

Universal

Populations Appropriate for This Best Practice

Drivers under 21 years old

Evaluating This Best Practice

The following are suggested areas to assess when implementing this practice:

- Assess reduced alcohol consumption among those under age 21
- · Assess rate traffic crashes and related fatalities among those under age 21

Research Conclusions

(Excerpt from Alcohol Alert, National Institute on Alcohol Abuse and Alcoholism, October 1996, No. 34, p. 1, PH 370.)

Raising the minimum legal drinking age (MLDA) has been accompanied by reduced alcohol consumption, traffic crashes, and related fatalities among those under 21.

A nationwide study found a significant decline in singlevehicle nighttime fatal crashes among drivers under 21 those most likely to involve alcohol - among drivers under 21 following increases in the MLDA.

Costs and Special Considerations

None identified

Contact Information

For more information on related topics (example: Save Lives: Recommendations to Reduce Underage Access to Alcohol, in the Resources section of the web site)

Join Together 441 Stuart Street, 6th Floor Boston, MA 02116 Phone: 617.437.1500

Fax: 617.437.9394

Web site: www.jointogether.org

BEST PRACTICE: Reconnecting Youth Program

(Eggert et al)

Description of Best Practice

(Excerpt from Preventing Drug Use Among Children and Adolescents: A Research-Based Guide, National Institute on Drug Abuse, 1997, pp. 27-28.)

Reconnecting Youth is a school-based indicated prevention program that targets young people in grades 9 through 12 who show signs of poor school achievement and potential for dropping out of high school. They also may show signs of multiple problem behaviors (such as substance abuse, depression, and suicidal ideation). The program teaches skills to build resiliency with respect to risk factors and to moderate the early signs of substance abuse.

To enter the program, students must have fewer than the average number of credits earned for their grade level, have high absenteeism, and show a significant drop in grades. Or a youth may enter the program if he or she has a record of dropping out or has been referred as a significant dropout

The program incorporates social support and life skills training with the following components:

- Personal Growth Class
- · A semester-long, daily class designed to enhance self-esteem, decision making, personal control, and interpersonal communication
- Social activities and school bonding to establish drug-free social activities and friendships, as well as improving a teenager's relationship to school
- · School system crisis response plan for addressing suicide prevention approaches

Risk Factors Addressed

Friends involved in problem behavior Academic failure Persistent antisocial behavior

Protective Factors Addressed

Bonding: School

CSAP Strategy

Education

Problem identification and referral

Type of Strategy

Indicated

Populations Appropriate for This Best Practice

Students in grades 6-12 who show signs of poor school achievement and potential for dropping out of high school

Evaluating This Best Practice

This best practice comes with an evaluation tool that can be used when implementing this strategy.

Evaluation Tool Cost:

The evaluation tools for process and outcome evaluation are included in the published curriculum. There is no additional cost involved at present. However, there is a cost if organizations want to the data analysis conducted for them. The fee for data analysis would be dependent on the size of the sample and evaluation tasks to be performed.

The following are suggested areas to assess when implementing this practice:

- · Assess improved school performance
- Assess increased bonding to school
- Assess increased social support
- Assess decreased deviant peer bonding
- Assess decreased anger and aggression

Research Conclusions

(Excerpt from Preventing Drug Use Among Children and Adolescents: A Research-Based Guide, National Institute on Drug Abuse, 1997, p. 28.)

Research shows that this program:

- Improves school performance
- Reduces drug involvement
- Decreases deviant peer bonding
- Increases: self-esteem, personal control, school bonding, and social support
- Decreases: depression, anger and aggression, hopelessness, stress, and suicidal behaviors

Further analysis indicates that the support of Personal Growth Class teachers contributes to decrease in drug involvement and suicide risk behaviors.

Costs as of January 2002 (Subject to Change)

Training Time: 4 - 5 days

Training Costs:

- \$750 per day per trainer (One trainer is required for each 5-8 persons being trained)
- · Trainers' travel and per diem costs
- \$189 plus tax/shipping for the Reconnecting Youth Curriculum
- · Reproduction costs for one training manual per partici-

Special Considerations

Please consider the following before selecting this strategy for your community:

- · It is recommended that the selection of individuals for training and Reconnecting Youth implementation be discussed with the program developers
- See the Reconnecting Youth manual, chapters one and two, for additional areas to take into consideration: Eggert, LL & Nicholas, LJ. (1995) Reconnecting Youth: A Peer Group Approach to Building Life Skills. Bloomington, IN: National Educational Service

Contact Information

For more information on this program, visit web site:

http://modelprograms.samhsa.gov.

For training or additional information on this best practice,

Liela J. Nicholas, M.Ed. Reconnecting Youth Prevention Research Program 14620 NE 65th Court Redmond, WA 98052

Phone: 425 861.1177 Fax: 425 861.8071 To order the curriculum, contact:

National Educational Service

1252 Loesch RD

Bloomington, IN 47404

E-mail: nes@nesonline.com

Phone: 800.733.6786 812 336.7790 Fax:

Web site: http://www.nesonline.com or:

For a copy of the source of this page, Drug Abuse Prevention for At-Risk Individuals by National Institute on Drug Abuse (1997) publication number PB# 97-209605, contact National Technical Information Services, 800.553.6847. Note: This book is part of a 5-book packet that costs \$83 plus \$5 han-

BEST PRACTICE: Residential Student Assistance Program

Description of Best Practice

(Excerpt from *Understanding Substance Abuse Prevention – Toward the 21st Century: A Primer on Effective Programs*, Center for Substance Abuse Prevention, unpublished document.)

The Residential Student Assistance Program in Westchester County, NY (Grant # 0618) was a five-year demonstration program begun in 1988. The program model was based on successful Employee Assistance Programs (EAPS) used by industry to identify and aid employees whose performance and lives had been adversely affected by substance use. Also feeding into the design of this effort were the successful experiences the county had when it initially implemented a Student Assistance Program in 1977 with the county's high school population.

A large part of this effort was designed to determine if the program could be adapted and remain effective with very high-risk, institutionalized adolescent youth. As such, the residential facilities included in this project included a locked county correctional facility, a residential treatment center for adolescents with severe psychiatric problems, a non-secure residential facility for juvenile offenders sentenced by the court, and three foster care facilities for abused, neglected, orphaned, or troubled adolescents placed by social service agencies. Participants were primarily 14-17-year-old African Americans and Hispanic origin youth.

The SAPs employ highly trained, professional Student Assistant Counselors (SACs) placed full or part-time in the residential facilities to provide culturally sensitive substance use prevention and intervention services, including:

- Establishing a supervisory partnership between an ATOD prevention agency and the residential child care facility.
- In this vein, a Substance Use Task Force composed of clinical, administrative, and line staff meet with the SAC weekly for about an hour to discuss relevant problems and develop plans aimed at their remediation.
- Providing training and consultation with the child care staff to increase their awareness and ownership of and skill in implementing ATOD prevention strategies
- Implementing an EAP for residential child care staff experiencing personal problems
- Assessing all new residents for physical, personal, and social resources as well as problems and substance use upon entry into the program
- Assisting residents through developing and leading a Residential Task Force. The task force meets for 30-45 minutes weekly and is designed to change the culture and norms of the facility, to decrease the stigma of interacting with SACs, and to increase self-referral for prevention/ treatment activities

- Providing individual educational and motivational counseling for residents who have chemically dependent parents (COAs/COSAs). These six to eight sessions of 45-minute duration are directed at increasing residents' awareness of parents' behavior and minimizing or eliminating the youths' own substance use.
- Implementing group counseling for COAs, COSAs, and substance users, in which groups of eight to ten residents discuss and role play for about 45 minutes for six to eight sessions on topics including adolescence, family problems, stress, and consequences of substance use. Other groups are designed to help residents identify and resist social and situational pressures to use substances, and to correct misperceptions of normative substance use. Each of these groups last eight to12 sessions and require about 45 minutes each.
- Making substance use treatment referrals outside the residential facility
- · Hosting 12-Step meetings at the facility

Please Note: Many prevention funding agencies classify this program a "treatment" program, not a prevention program. Please check with your funding agency before implementing with prevention dollars.

Risk Factors Addressed

Persistent antisocial behavior Family history of substance abuse

Protective Factors Addressed

None identified

CSAP Strategy

Information dissemination Education Problem identification and referral

Type of Strategy

Indicated

Populations Appropriate for This Best Practice

- · Institutionalized adolescents, 14-17 years
- · African Americans
- Hispanic

Evaluating This Best Practice

The following are suggested areas to assess when implementing this practice:

- · Assess decrease in use of alcohol, tobacco, and marijuana
- · Assess decrease in quantity and number of drugs used

Research Conclusions

(Excerpt from Understanding Substance Abuse Prevention - Toward the 21st Century: A Primer on Effective Programs, Center for Substance Abuse Prevention, unpublished document.)

- Evaluation data demonstrated that services offered by the Residential SAP were a key ingredient in a marked decrease in substance use among participants.
- Further, youth who participated in multiple services showed an additional decline in substance use between the first and second post-tests.

These data indicate the observed differences over time between treatment and comparison groups are quite reliable and indicate high levels of program impact.

Costs and Special Considerations

Please inquire of the contact listed below.

Contact Information

For more information on this program, visit web site:

http://modelprograms.samhsa.gov

For training, technical assistance, and materials contact: Ellen Morehouse, ACSW, CASAC **Student Assistance Services** 660 White Plains Rd Tarrytown, NY 10591

E-mail: sascorp@aol.com 914.332.1300 Phone:

914.366.8826 Fax:

Description of Best Practice

(Excerpts taken from *Preventing Problems Related to Alcohol Availability: Environmental Approaches: Practitioners' Guide,* Center for Substance Abuse Prevention, pp. 11-13.)

The behavior of people who serve alcohol and the policies of drinking establishments can influence the behavior of the patrons. For example, servers may encourage heavy drinking; allow heavy drinking to continue ignored, promoting intoxication; or foster problems associated with intoxication, such as disruptive behavior, fights and resulting injuries, or driving while intoxicated (DWI). Training servers and management to watch for and recognize the warning signs of intoxication can help reduce the risk that patrons will become intoxicated and harm themselves or others. It may be necessary to modify management policies to discourage an atmosphere of "anything goes."

Activities include:

- · Conducting responsible server training programs
- Establishing a state law requiring responsible server training
- Enforcing a county law prohibiting alcohol service to intoxicated patrons
- Establishing a state Liquor Control Board with comprehensive prevention activities.
- Establishing a coalition of representatives from the hospitality industry and the prevention field to promote and ensure responsible beverage service.

Lessons Learned

- Server training programs differ in type, intensity, length, and focus. There is no evidence that certain server training program characteristics are associated with greater or lesser effectiveness.
- Server training programs are more likely to exist when stakeholders (people with a special interest in the problem) offer support, organization, and interest.
- States, counties, and other local jurisdictions are appropriate vehicles for establishing server training programs.
- Responsible beverage service programs are most likely to succeed when servers and managers know that the law will be enforced or realize that they assume significant liability if they serve intoxicated or underage individuals.

Recommendations for practice include:

- Enforce the law
- Target trouble spots
- Keep the legal burden on owners
- · Provide incentives
- Intervene early
- Close license loopholes
- Avoid grandfather exceptions
- Help establish standards for beverage service activities
- · Be sure alternatives to alcohol are offered

· Provide continuous server training

Risk Factors Addressed

Community laws and norms Availability of drugs

Protective Factors Addressed

Healthy beliefs and clear standards

CSAP Strategy

Environmental

Type of Strategy

Universal

BEST PRACTICE: Responsible Beverage Service

Populations Appropriate for This Best Practice

None specifically identified

Evaluating This Best Practice

The following are suggested areas to assess when implementing this practice:

- Assess the number of illegal sales to intoxicated and underage individuals
- Assess the change in responsible service practices and management practices

Research Conclusions

(Excerpts taken from *Preventing Problems Related to Alcohol Availability: Environmental Approaches: Practitioners' Guide,* Center for Substance Abuse Prevention, p. 12.)

The research and practice evidence reviewed indicates that it is possible to implement responsible beverage server interventions:

- There is strong evidence that server training and policy interventions are effective in curbing illegal sales to intoxicated and underage individuals when these interventions are combined with enforcement activities.
- There is medium evidence that server training and policy interventions are effective in improving some forms of server behavior, at least in the short term.
- There is medium evidence that server training can lead to more responsible service practices and management policies.

Costs and Special Considerations

Not available

Contact Information

For more information on how to implement this best practice order a free copy of CSAP's *Preventing Problems Related to Alcohol Availability: Environmental Approaches*, 1999, from SAMHSA's National Clearinghouse for Alcohol and Drug Information (NCADI) 800.729.6686, or web site: http://ncadi.samhsa.gov, order no. "PHD 822, 823 and 825."

BEST PRACTICE: Restriction of Advertising and Promotion of Tobacco

Description of Best Practice

(Excerpt from: Reducing Tobacco Use Among Youth: Community-Based Approaches: A Guideline for Prevention Practitioners, Center for Substance Abuse Prevention, 1997, Prevention Enhancement Protocols Systems Series 1, pp. 22-23.)

The primary goal of this prevention approach is to decrease child and adolescent exposure to tobacco promotion and protobacco influences.

Research demonstrates that tobacco company sales promotions are reaching adolescents and that this exposure may put them at greater risk for smoking. Therefore, the reduction of youth exposure to particular types of marketing or to the quantity of marketing should reduce adolescent smok-

Activities

- Provide media advocacy and the threat of adverse publicity through protesting events sponsored by the tobacco industry
- Assist event promoters by providing alternative, non-tobacco funding
- Develop policies that ban tobacco industry sponsorship of sporting and cultural events
- Promote tobacco-free events
- Develop tobacco-free messages and embed them in sports education
- · Advertise tobacco-free events
- · Include tobacco-free messages in the event's promotional materials

Risk Factors Addressed

Community laws and norms favorable toward drug use

Protective Factors Addressed

Healthy beliefs and clear standards

CSAP Strategy

Environmental

Type of Strategy

Universal

Populations Appropriate for This Best Practice

No specific populations

Evaluating This Best Practice

The following are suggested areas to assess when implementing this practice:

- Assess establishment of policies restricting or prohibiting tobacco use
- · Assess rates of adolescent smoking

Research Conclusions

(Excerpt from: Reducing Tobacco Use Among Youth: Community-Based Approaches: A Guideline for Prevention Practitioners, Center for Substance Abuse Prevention, 1997, Prevention Enhancement Protocols Systems Series 1, pp. 22-23.)

The practice evidence reviewed indicates that it is possible to implement efforts designed to eliminate tobacco sponsorship of events, to block tobacco product promotion, and to provide non-tobacco industry sponsorship of events:

- · There is strong evidence that it is possible to establish policies that ban tobacco industry sponsorship of social and cultural events and influence product promotion practices.
- There is medium evidence that policies banning tobacco industry promotion of activities such as music festivals and sporting events will reduce adolescent use of tobacco.

Lessons Learned From Reviewed Evidence

The need for alternative funding is an essential component for interventions that are designed to prohibit existing and ongoing tobacco industry sponsorship of a currently active event. In particular, practitioners and community groups can develop lists of potential alternative sponsorship. For example, local businesses that are not currently involved in sponsoring the event can be approached.

Through the establishment of working relationships with local potential sponsors, businesses can view sponsorship of events as part of their civic responsibilities and as part of a community partnership process. In addition, existing nontobacco event sponsors may be willing to increase their level of sponsorship if there is no tobacco industry sponsorship. They may have recommendations for other potential sponsors, perhaps some of their industrial partners.

Costs and Special Considerations

None identified

Contact Information

For more information on this best practice, order a free copy of the following publications from SAMHSA's National Clearinghouse for Alcohol and Drug Information (NCADI)

Toll free: 800.729.6686

Reducing Tobacco Use Among Youth: Community-Based Approaches, Center for Substance Abuse Prevention, 1997, Prevention Enhancement Protocols Systems Series 1, publication order no. "PHD 744" (for 12-page community guide) "PHD 745" (for prevention practitioner's guide) and "PHD 746" (full document).

For more information on related topics (example: Save Lives: Recommendations to Reduce Underage Access to Alcohol), in the Resources section of the web site.

Join Together 441 Stuart Street, 6th Floor Boston, MA 02116

Phone: 617.437.1500 Fax: 617.437.9394

Web site: www.jointogether.org

BEST PRACTICE: Retailer-Directed Interventions

(Tobacco Specific)

Description of Best Practice

(Excerpt from Reducing Tobacco Use Among Youth: Community-Based Approaches: A Guideline for Prevention Practitioners, Center for Substance Abuse Prevention, 1997, Prevention Enhancement Protocols System Series 1, pp. 12-15.)

The primary goal of tobacco retailer-directed interventions is to reduce tobacco sales to minors and tobacco purchases by minors. Within this approach, research and practice is divided into three clusters: merchant and community education about adolescent tobacco use and laws prohibiting tobacco sales to minors, enactment of laws prohibiting tobacco sales to minors and enforcement of laws prohibiting tobacco sales to minors combined with merchant and community education about adolescent tobacco use and the laws prohibiting tobacco sales to minors.

Activities include:

Merchant and Community Education

- · Educate clerks and merchants about adolescent tobacco problems, existing laws prohibiting tobacco sales to minors, and their responsibility for complying with these laws.
- Educate the public, community groups, and mass media about adolescent tobacco problems and existing laws prohibiting tobacco sales to minors.
- Enlist community support for and involvement in educational interventions.
- Monitor and publicize the results of attempts made by adolescents to purchase tobacco.
- · Provide warning signs in retail stores about laws prohibiting tobacco sales to minors.

Enactment of Laws to Prohibit Tobacco Sales to Minors

- · Enact local ordinances restricting the sale of tobacco to minors.
- · Place cigarette vending machines in locations inaccessible to minors.
- Require locking devices on cigarette vending machines that merchants must unlock for a purchase to occur.
- · Require merchant licenses for vending machines.
- Require merchant licenses for over-the-counter sales of tobacco products.
- Require merchants to ask for proof of age when a customer appears to be underage.
- · Require that merchants post warning signs about laws restricting tobacco sales to minors.
- Enact civil penalties (for example, suspension or revocation of licenses) for violating laws restricting tobacco sales to minors.

Enforcement of Laws and Community Education

- · Seek and secure community partnership, support, and sponsorship of prevention activities.
- Establish the rate of tobacco sales to minors by monitoring purchase attempts.
- · Visit merchants to educate them about the laws prohibiting sales to minors and the consequences of noncompli-
- · Have youth and law enforcement personnel work together to deliver merchant education materials (for example, tips on how to refuse sales to minors, warning signs, fact sheets).
- Monitor and publicize the results of adolescents' attempts to purchase tobacco products.
- · Provide positive reinforcement (for example, financial rewards, product incentives, media recognition) to merchants who refuse to sell tobacco to adolescents.
- · Hold press conferences and similar events to publicize activities.

Risk Factors Addressed

Availability of drugs Community laws and norms

Protective Factors Addressed

Healthy beliefs and clear standards

CSAP Strategy

Environmental

Type of Strategy

Universal

Populations Appropriate for This Best Practice

Studies not done with specific populations

Evaluating This Best Practice

The following are suggested areas to assess when implementing this practice:

- Determine the number and type of policies that were changed related to tobacco sales and minors
- · Determine whether the number of tobacco sales to minors decreased

Research Conclusions

Of the studies reviewed and summarized in Reducing Tobacco Use Among Youth: Community-Based Approaches: A Guideline for Prevention Practitioners (see below) there is medium evidence that combined merchant and community education results in a short-term decrease in over-the-counter tobacco sales to minors.

Costs and Special Considerations

None identified

Contact Information

For more information on this best practice, order a free copy of the following publications from SAMHSA's National Clearinghouse for Alcohol and Drug Information (NCADI) at:

Toll free: 800. 729.6686

Reducing Tobacco Use Among Youth: Community-Based Approaches, Center for Substance Abuse Prevention, 1997, Prevention Enhancement Protocols Systems Series 1, publication order no. "PHD 744" (for 12-page community guide) "PHD 745" (for prevention practitioner's guide) and "PHD 746" (full document).

BEST PRACTICE: Seattle Social Development Project

(Hawkins et al)

Description of Best Practice

(Excerpt from Preventing Drug Use Among Children and Adolescents, National Institute on Drug Abuse, 1997, page 23.)

A universal program, the Seattle project is a school-based intervention for grades one through six that seeks to reduce shared childhood risks for delinquency and drug abuse by enhancing protective factors. The multi-component intervention trains elementary school teachers to use active classroom management, interactive teaching strategies, and cooperative learning in their classrooms.

At the same time, as children progress from grades one through six, their parents are provided a training session called "How to Help Your Child Succeed in School," a family management skills training curriculum called "Catch 'Em Being Good," and the "Preparing for the Drug-Free Years" curriculum. The interventions are designed to enhance opportunities, skills, and rewards for children's pro-social involvement in both school and family settings, thereby increasing their bonds to school and family, and commitment to the norm of not using drugs.

Risk Factors Addressed

Family management problems Early antisocial behavior Academic failure Low commitment to school Friends involved in problem behaviors

Protective Factors Addressed

Opportunities, skills, and recognition Bonding: Family and school Healthy beliefs/Clear standards

CSAP Strategy

Information dissemination Education

Type of Strategy

Universal

Populations Appropriate for This Best Practice

Grades 1-6

Evaluating This Best Practice

The following are suggested areas to assess when implementing this practice:

- · Assess decreases in aggressive behavior.
- Assess improved academic skills.
- Assess greater commitment to school.
- Assess less misbehavior in school.

Research Conclusions

(Excerpt from Preventing Drug Use Among Children and Adolescents, National Institute on Drug Abuse, 1997, page 23.)

Long-term results indicate positive outcomes for students who participated in the program: reductions in antisocial behavior, improved academic skills, greater commitment to school, reduced levels of alienation and better bonding to pro-social others, less misbehavior in school, and fewer incidents of drug use in school.

Contact Information

The Seattle Social Development Project is currently being converted into a comprehensive school reform program entitled SOAR (Skills, Opportunities, and Recognition). For general information, contact:

Sarah Clay **Channing Bete Company** One Community Place South Deerfield, MA 01373-0200

clay@channing-bete.com

800.828.2827 Phone. Fax: 413.665.711

Web site: www.channing-bete.com

For technical assistance, contact:

Kevin Haggerty Phone: 206.543.3188

Richard Catalano Phone: 206.543.6382

sdrg@u.washington.edu E-mail: Social Development Research Group University of Washington 9725 3rd Avenue NE, Suite 401 Seattle, WA 98115-2024

BEST PRACTICE: SMART Leaders

Description of Best Practice

(Excerpt taken from http://modelprograms.samhsa.gov)

This model program is a 2-year booster program for youth who have completed "Stay SMART," a component of Boys & Girls Clubs of America's SMART Moves program. It reinforces the substance abuse prevention skills and knowledge of the first program, with sessions on self-concept, coping with stress, and resisting media pressures.

SMART Leaders is a curriculum-based program that uses role-playing, group activities, and discussion to promote social and decision-making skills in racially diverse 14- to 17-year-olds. As participants advance in the program, they are involved in educational discussions on alcohol, tobacco, and other drugs and have the opportunity to recruit other youth for the program and assist with sessions offered to younger boys and girls. Evaluation results show the effectiveness of this multiyear approach in promoting refusal skills and creating drug-free peer leaders.

The SMART Leaders program, with other SMART Moves components, can be implemented in community-based youth organizations, recreation centers, and schools, in collaboration with all local Boys & Girls Club. All the demonstration projects were implemented in Boys & Girls Clubs, a number of which are in or adjacent to public housing projects.

The SMART Leaders activity component consists of three parts:

- An educational curriculum focusing on self-esteem, coping with stress, and resisting pressures to use drugs and to engage in sexual activity
- 2. Peer leadership activities
- 3. Monthly youth activities

 $Successful\ replication\ of\ the\ SMART\ Leaders\ model\ involves:$

- · Structured experiential and discussion sessions for youth
- Youth activities/outings

Please Note: This program is intended for implementation within existing Boys & Girls Clubs.

Risk Factors Addressed

Friends who use Favorable attitudes toward drug use

Protective Factors Addressed

Skills: Problem-solving and social/interpersonal skills Bonding: With positive adult role model and positive peers

CSAP Strategy

Information dissemination Education

Type of Strategy

Universal

Populations Appropriate for This Best Practice

- · 14-17 years old
- · African American
- Hispanic
- Caucasian

Evaluating This Best Practice

The following are suggested areas to assess when implementing this practice:

- · Assess decrease in alcohol, tobacco, and marijuana use
- · Assess increase in peer resistance skills
- · Assess perceived social benefits from using ATOD
- Assess deviant peer bonding

Research Conclusions

(Excerpt from *Understanding Substance Abuse Prevention – Toward the 21st Century: A Primer on Effective Programs*, Center for Substance Abuse Prevention, unpublished document.)

Results from the self-report questionnaire showed overall effectiveness of the Stay SMART prevention program, and more particularly, the effectiveness of the SMART Leaders booster program, in maintaining and furthering initial gains made in the initial Stay SMART program. More specifically:

- Overall drug use, marijuana-related behavior, cigaretterelated behavior, alcohol-related behavior, and ATOD drug use knowledge was significantly less in the SMART + Boosters group and Stay SMART only group compared to the control group.
- Furthermore, the Stay SMART + Boosters group versus the control group perceived significantly fewer social benefits from smoking marijuana and drinking alcoholic beverages.

Contact Information

For more information on this program, visit web site:

http://modelprograms.samhsa.gov

For training, technical assistance, materials, and/or more information, call toll free 877.773.8546.

Boys & Girls Clubs of America 1230 West Peachtree Street Northwest Atlanta, GA 30309-3447

E-mail: mcpuig@bgca.org Phone: 404.487.5766 Fax: 404.487.5789

Web site: http://www.bgca.org

BEST PRACTICE: Social Competence Promotion Program for Young Adolescents

(formerly Weissberg's Social Competence Promotion Program)

Description of Best Practice

(Excerpt taken from materials provided by SCPP-YA, Dept. of Psychology, Chicago, IL)

The Social Competence Promotion Program for Young Adolescents (SCPP-YA) is a middle school prevention program that teaches students cognitive, behavioral, and affective skills and encourages them to apply these skills in dealing with daily challenges, problems, and decisions.

The 45-session SCPP-YA has 3 modules. The first module includes 27 lessons of intensive instruction in social problem-solving (SPS) skills. These foundational lessons are followed by two 9-session programs that teach students to apply SPS skills to the prevention of substance abuse and highrisk sexual behavior. To foster the application and generalization of SPS concepts and skills to daily life, teachers are trained to model problem-solving to students in situations other than formal classroom lessons, and to guide and encourage students to try out problem-solving strategies in school, at home, and in the community.

Risk Factors Addressed

None specifically identified

Protective Factors Addressed

Skills: Problem solving/coping

CSAP Strategy

Education

Type of Strategy

Universal

Populations Appropriate For This Practice

African American Caucasian Grades 2-4 and Grades 6-9

Evaluating This Practice

The following are suggestions of areas you may want to assess if you implement this promising practice:

- Assess the problem-solving and coping skills of partici-
- Assess the level of alcohol, tobacco, and other drug use of participants.

Research Conclusions

(Excerpt taken from materials provided by SCPP-YA, Dept. of Psychology, Chicago, IL)

Post-test only research evaluations indicate positive program effects on students' problem-solving and stress-management skills, pro-social attitudes about conflict, social behavior, and alcohol use.

Costs and Special Considerations

Please inquire of the contact below.

Contact Information

For information, training and materials: Roger Weissberg

Department of Psychology (M/C 285) University of Illinois-Chicago

312.355.0559

1007 West Harrison Street

Chicago, IL 60607-7137 E-mail: rpw@uic.edu Phone: 312.413.1012

Fax:

BEST PRACTICE: Stop Teenage Addiction to Tobacco

Description of Best Practice

(Excerpt from http://www.samhsa.gov/csapmodelprograms)

The S.T.A.T. initiative is an environmental campaign to enforce laws against tobacco use by minors and to stimulate communities to implement other strategies such as banning vending machines or installing lockout devices on vending machines to curtail youth access to tobacco. Where traditional youth smoking prevention initiatives have focused on reducing the demand or desire for tobacco among youth, the S.T.A.T. effort focuses on cutting off the supply of tobacco to minors. The town of Woodridge, Illinois, was the first in the nation to put a tough enforcement program in place. The aim of the program was to convince merchants to obey the law by refusing to sell tobacco to minors. As a result of this enforcement program, Woodridge's rate of tobacco use among teenagers was reduced by half.

S.T.A.T. focuses on cutting off the supply of tobacco to minors by enforcing laws that prohibit the sale of tobacco to this underage group. A key strategy to improving enforcement is conducting compliance tests. The following strategy for compliance testing was undertaken by six communities in Massachusetts.

- Underage youth enter a place of business to purchase tobacco while an adult supervisor waits outside. Youth involved in compliance testing are instructed to be honest when asked their age and not to carry proof of identification.
- Youth involved in compliance testing must have parental consent and must sign a statement outlining their responsibilities. In addition, they receive 1 to 2 hours of group training to prepare for the compliance tests.
- The adult supervisor waits in the car while the youth enters the store. When the youth returns, he or she reports what transpired. Any purchased tobacco is immediately labeled with the date of sale; name of the adult supervisor; and the name, address, and permit number of the vendor.
- Violation notices are written for violators. These notices are delivered either by mail or in person at the end of the day, but never at the time of the inspection. To do so might launch a merchant phone tree action, reducing the number of effective compliance inspections possible that day.
- In cases of vending machines without locking devices, youth are instructed to approach the vending machine and attempt to make a purchase. If the vending machine is locked, the youth are instructed to ask an employee to unlock the machine.
- Over-the-counter vendors included in the compliance testing in Massachusetts were convenience stores, pharmacies, liquor stores, and gasoline stations. All of the vending machines were located in restaurants.

It is important to re-inspect violators frequently to determine whether the penalty has had the desired effect of eliminating a source of illegal sales.

Risk Factors Addressed

Community laws and norms favorable toward alcohol use Availability of tobacco

Protective Factors Addressed

Healthy beliefs and clear standards

CSAP Strategy

Environmental

Type of Strategy

Universal

Populations Appropriate for This Best Practice

- Youth
- Law enforcement, vendors, and other community groups

Evaluating This Best Practice

The following suggestion is an area you may want to assess if you implement this best practice:

 Assess merchant compliance and vendor compliance rate with tobacco purchase laws.

Research Conclusions

(Excerpt from http://modelprograms.samhsa.gov)

There has been a measurable improvement in merchant compliance in Massachusetts over the past years. Each of the communities in the Massachusetts study reached 90 percent (or above) vendor compliance rate, showing that enforcement programs were effective. Three months after a local law requiring lockout devices on all machines went into effect, a minor was able to purchase tobacco from 19 percent of vending machines equipped with locks in comparison to 65 percent of machines without locks.

Costs and Special Considerations

Not available

Contact Information

For more information on this program, visit web site: http://modelprograms.samhsa.gov

No technical assistance, training, or manuals are available for this strategy.

For questions related to STAT, contact:

Judy Sopenski, SQUADS Consultant and Trainer Community Intervention 529 South 7th Street, Suite 570 Minneapolis, MN 55415

E-mail: jsopenski@hotmail.com

Phone: 800.328.0417

BEST PRACTICE: Strengthening Families Program

Description of Best Practice

(Excerpts from CSAP's Model Programs web site, http://modelprograms.samhsa.gov)

The Strengthening Families Program (SFP) involves elementary school aged children (6 to 12 years old) and their families in family skills training sessions. SFP uses family systems and cognitive-behavioral approaches to increase resilience and reduce risk factors for behavioral, emotional, academic, and social problems. It builds on protective factors by:

- Improving family relationships
- · Improving parenting skills
- Increasing the youth's social and life skills

The SFP curriculum is a 14-session behavioral skills training program of 2 hours each. Parents meet separately with two group leaders for an hour to learn to increase desired behaviors in children by increasing attention and rewards for positive behaviors. They also learn about clear communication, effective discipline, substance use, problem solving, and limit setting.

Children meet separately with two children's trainers for an hour, to learn how to understand feelings, control their anger, resist peer pressure, comply with parental rules, solve problems, and communicate effectively. Children also develop their social skills and learn about the consequences of substance abuse.

During the second hour of the session, families engage in structured family activities, practice therapeutic child play, conduct family meetings, learn communication skills, practice effective discipline, reinforce positive behaviors in each other, and plan family activities together.

Booster sessions and on-going family support groups for SFP graduates increase generalization and the use of skills learned.

SFP offers incentives for attendance, good behavior in children, and homework completion to increase program recruitment and participation.

Risk Factors Addressed

Family management problems Early antisocial behavior Parental attitudes and involvement Family history

Protective Factors Addressed

Bonding: Family

CSAP Strategy

Information dissemination Education Problem identification and referral

Type of Strategy

Universal Selective Indicated

Populations Appropriate for This Best Practice

- · Six- to eleven-year-old children
- Children of substance abusers
- Children with conduct problems
- African American
- Caucasian
- Asian/Pacific Islander
- Hispanic/Latino

Evaluating This Best Practice

The following are suggested areas to assess when implementing this practice:

- · Assess improved behavioral outcomes (e.g. aggressiveness and conduct disorders) among participating chil-
- Assess reductions in family conflict.
- Assess improved family communication and organiza-

Research Conclusions

(Excerpt from materials provided by Dr. Karol Kumpfer in December 2001.)

The Strengthening Families Program (SFP) reduces risk factors and strengthens resilience to substance abuse in participating elementary school-aged children. Immediate results by the ending of the 14-week family skills training program include the following statistically significant outcomes:

Immediate Outcome Results:

- Increased parenting skills in 98% of parents attending
- Improved parent/child relationships in 93% of families
- 92% of attending families holding family meetings at least monthly
- 84% of attending families holding family meetings at least
- Reduced family conflict in 75% of families
- Decrease excessive physical punishment in 82% of fami-
- Increased social and life skills in 98% of the children
- Increased pro-social behavior in 98% of children
- Parent involvement with the schools increased significantly one year after participation in school-based SFP
- Improved academic performance and grades in 55% of
- · Improved school bonding and attachment in 65% of chil-
- Decreased emotional problems and child depression in
- Decrease behavior problems, conduct disorders and aggressive behavior in 65% of children

- Decreased parent tobacco, alcohol, and drug use in 84% of parents attending
- Decreased children's tobacco, alcohol, and drug use in 77% of children using

Long-term Five-Year Follow-up Results

- Improved clear directions to children in 99% of parents
- Increased quality time with children in 97% of parents
- Increased verbal rewards and praise of children's appropriate behaviors in 97% of parents
- Appropriate consequences and punishment in 95% of parents
- Increased enjoyment of the child in 94% of parents
- Improved problem solving with child by 84% of parents
- Increased parent/child relationships in 75% of families
- 82% of parents were still conducting Child's Game or having a scheduled play time with child
- Improved family problem solving reported in 78% of families
- Reduced family stress and family conflict reported in 75% of families
- · 68% of families holding family meetings monthly
- Increased effective family communication reported in 67% of families
- 65% of families reporting improved positive family feelings
- 62% of families reporting improvements in having fun together as a family
- 37% of families still holding family meetings weekly

Costs as of December 2001 (Subject to Change)

Training Time and Cost:

- A two-day training is \$2,700 plus travel expenses.
- A three-day training (recommended for groups over 25

and evaluated grants) is \$3,700 plus travel expenses.

For additional cost information, please visit: http://www.strengtheningfamiliesprogram.org/

or inquire of the contact listed below.

Special Considerations

Please inquire of the contact listed below.

Contact Information

For more information on this program, visit http://modelprograms.samhsa.gov and http://www.strengtheningfamiliesprogram.org/

For SFP training information, contact:

Dr. Henry Whiteside

Lutra Group

E-mail: hwhiteside@lutragroup.com

Phone: 801.583.4601

For additional information, contact:

Dr. Karol Kumpfer University of Utah

Department of Health Promotion and Education

250 East 1850 East Room 215 Salt Lake City, UT 84112

E-mail: karol.kumpfer@health.utah.edu

Phone: 801.581.7718 Fax: 801.581.5872

BEST PRACTICE: Strengthening Families Programs: For Parents and Youth 10-14

(Iowa Strengthening Families Program)

Description of Best Practice

(Excerpt from Strengthening America's Families' web site, http://www.strengtheningfamilies.org/index.html)

The Strengthening Families Program: For Parents and Youth 10-14 (SFP 10-14) resulted from an adaptation of the Strengthening Families Program (SFP) developed at the University of Utah. Formerly called the Iowa Strengthening Families Program, the long range goal of the curriculum is reduced substance use and behavior problems during adolescence. Intermediate objectives include improved skills in nurturing and child management by parents, improved interpersonal and personal competencies among youth, and prosocial skills in youth. Parents of all educational levels are targeted and printed materials for parents are written at an 8th grade reading level. All parent sessions, two youth, and two family sessions use videotapes portraying pro-social behaviors and are appropriate for multi-ethnic families.

The SFP 10-14 has seven two-hour sessions for parents and youth, who attend separate skill-building groups for the first hour and spend the second hour together in supervised family activities. Four booster sessions are designed to be used six months to one year after the end of the first seven sessions in order to reinforce the skills gained in the original sessions. Youth sessions focus on strengthening goal setting, dealing with stress and strong emotions, communication skills, increasing responsible behavior, and improving skills to deal with peer pressure. Booster sessions focus on making good friends, handling conflict and reinforcing skills learned in the first seven sessions. Parents discuss the importance of both showing love to their youth while, at the same time, setting appropriate limits. Topics include making house rules, encouraging good behavior, using consequences, building bridges, and protecting against substance abuse. Booster sessions focus on handling parents' own stress, communicating when partners don't agree and reinforcing earlier skills.

The videos portray white, African American, and Hispanic families. A nonvideo version of the program is available for non-English speaking families and for ethnic groups that may not relate to the actors in the video vignettes. This version includes text for on-site role plays in Spanish.

Risk Factors Addressed

Family conflict Family management problems

Protective Factors Addressed

Healthy beliefs and clear standards Bonding Skill building

CSAP Strategy

Education

Type of Strategy

Universal

Populations Appropriate for This Best Practice

- Children ages 10-14 and their families
- · Low income families

Evaluating This Best Practice

This best practice comes with an evaluation tool that can be used when implementing this strategy. There is no cost for the evaluation tool as it is included in the teaching manual.

The following are suggested areas to assess when implementing this practice:

- · Assess increase in family management skills
- Assess decrease in family conflict
- · Assess increase in family cohesion

Research Conclusions

(Excerpt from Strengthening America's Families' web site, http://www.strengtheningfamilies.org/index.html)

The study (using the original Iowa Strengthening Families Program) is now in its fifth year and includes 442 families in areas with a high percentage of economically disadvantaged families.

Analysis of the data comparing pre- and post-test and follow-up assessments indicated that both the youth and parents made significant gains in targeted behavior. For example, child problem behavior outcomes (e.g. substance use, conduct problems, school-related problem behaviors, peer resistance, and affiliation with antisocial peers) have shown positive program effects over time. These positive changes are indicated by both delayed onset of problem behaviors and relatively more gradual increases in these behaviors over the three years following implementation of the program.

At the post-test and follow-up evaluations, there are significant positive differences between parents who attended the intervention and the control group in behaviors specifically targeted by the intervention, as well as the more general parenting outcomes of parent-child affective quality and general child management. Two other longitudinal studies are underway.

Costs as of December 2001 (Subject to Change)

Training Time: 16 hours

Training Costs:

See also Special Considerations. Approximately \$4,000 to \$4,500 for a two-day training, or \$5,000 to \$5,500 for a threeday training:

• \$2,500 plus \$1,500 travel, food and lodging for two trainers: The two-day training is appropriate for facilitators working with African American, English-speaking Hispanic and white families.

\$3,500 plus \$1,500 travel, food and lodging for two trainers: Three-day trainings, conducted by lead trainers, are available for groups needing to make adaptations for different ethnic groups including non-English speaking parents.

These trainings are required for:

- 1) Sites conducting scientific evaluation of the curriculum
- Sites in which modifications to the curriculum are required to make the program sensitive to ethnically-diverse populations such as non-English speaking parents
- 3) Sites including train-the-trainer sessions

Strategy Implementation:

- \$4,000 for 2-day training
- · \$775 for teaching manuals and videos
- \$500 for family supplies (for 30 families)
- \$3600 for staff (\$30/teaching hour for 3 staff for 3 program series 10 families/group)
- Variable food and transportation costs (varies if donated or purchased, etc.)

Special Considerations

Please consider the following before selecting this strategy for your community:

- The reading level for parent participants is 8th grade.
- A non-video version for parent sessions is available to use with non-English speaking parents, in conjunction with the basic teaching manual.

Training

- In order for a group to be certified to teach the program, groups of at least three facilitators per program site must receive training. There are no specific degree requirements and community members who have had non-professional experience leading groups of youth and/or families often make excellent facilitators.
- Sponsoring groups often open the training to other local agencies or groups, charging a registration fee of about \$300 per person. These fees help offset the cost of training.
- Alternatives to hosting an on-site training are available but often bring the cost close to the expense of hosting a training on-site.

Contact Information

For more information on training, materials and the evaluation of this program, visit the following web site:

http://www.extension.iastate.edu/sfp

Additional contact:

Virginia Molgaard, Ph.D. Institute for Social and Behavioral Research Iowa State University Center for Rural Health 2625 North Loop Drive, Suite 500 Ames, IA 50010

E-mail: vmolgaar@iastate.edu

Phone: 515.294.8762 Fax: 515.294.3613

BEST PRACTICE: Strengthening Hawai'i Families

Description of Best Practice

(Description provided by Strengthening Hawai'i Families staff in January 2002.)

Strengthening Hawai'i Families (SHF), developed by the Coalition for a Drug-Free Hawaii, is a primary prevention program that applies values clarification in a multicultural environment. SHF is designed to prevent and reduce substance use by reducing risk factors associated with substance abuse and improving protective factors associated with resilient families.

A team of four facilitators work with a group of 6-10 families on the importance of clarifying and practicing family values, strengthening 'ohana (family) relationships and communication skills, and making healthy lifestyle choices. SHF brings family members together to help families discover for themselves what works best for them. Common throughout SHF activities is a process where families have the opportunity to share their culture, experience other cultures, and honor the rich diversity of cultures in Hawaii.

The SHF program is presented in 14 consecutive weekly sessions, each lasting two and a half hours. The SHF program includes three training components: a parent training program, a children's skills training program, and a family skills training program. Each session begins with the parents and children together for energizer activities, multicultural stories, goals and objectives, meals, and family skills training. Then the parents and children meet separately in their respective training groups for additional activities and skills training. The session ends with the parents and children group reconvening to share what they learned, practice skills, and bond with other families.

Trained facilitators work with families to cover the following topics:

- exploring and practicing family values
- cultural and generational continuity
- creating a family vision
- goal setting
- personal and family resilience
- connecting with one another
- communication
- making choices
- problem-solving
- limit setting
- anger management
- wellness including substance abuse prevention
- healthy lifestyle choices
- 'ohana (family) time

Risk Factors Addressed

Family conflict Family management problems

Protective Factors Addressed

Healthy beliefs and clear standards **Bonding** Skill building

CSAP Strategy

Education

Type of Strategy

Selective

Populations Appropriate for This Best Practice

- · Rural communities
- Children ages 8-11 and their families
- Elementary school
- · Public housing
- Asian/Pacific Islanders

Evaluating This Best Practice

This best practice does not come with an evaluation tool that can be used when implementing this strategy at this time. The following are suggested areas to assess when implementing this practice:

- · Assess increase in family management skills
- Assess decrease in family conflict
- Assess increase in family cohesion
- · Assess improvements in communication skills

Research Conclusions

(Excerpt from Strengthening America's Families' web site, http://www.strengtheningfamilies.org/index.html)

SHF has been shown to have a positive impact on the families that participated. The University of Hawaii Social Welfare Evaluation and Research Unit (SWERU) found significant improvement in family cohesion, family organization, and family communication; and a significant decrease in family conflict as well as decrease in parental depression. These findings relate to the goal to decrease risk factors and to increase resiliency/protective factors in youth and their families.

Follow-up research done by SMS, Inc, to determine the longterm impacts of participation found that past participants reported:

- · Better relationships among family members
- A clearer understanding of parental roles
- More awareness of children's needs
- Improved behaviors for children
- General improvement in communication skills for all fam-

Participants also remarked on the amount of bonding and fellowship that accompanied each SHF session.

Costs as of December 2001 (Subject to Change)

Training Time: 13 hours

Training Costs:

\$349 per person – includes two day training of facilitators workshop, comprehensive training manual, facilitator's guide, all training materials, SHF facilitator certification for one year, and three hours of technical assistance to each team of SHF facilitators completing training. Travel, lodging, food, and facilities not included.

Strategy Implementation:

Please call Coalition for a Drug-Free Hawaii for cost.

Special Considerations

Please consider the following before selecting this strategy for your community:

· Review and apply cultural adaptation considerations.

Contact Information

For training or additional program information, contact:

Cheryl Kameoka

Coalition for a Drug-Free Hawaii

1130 North Nimitz Highway, Suite A259

Honolulu, HI 96817

E-mail: cdfh@pixi.com

Phone: 808.545.3228 x 28

Fax: 808.545.2686

Web site: http://www.drugfreehawaii.org

BEST PRACTICE: Syracuse Family Development Research Program

Description of Best Practice

(Excerpt reprinted with permission from the Center for the Study and Prevention of Violence, Institute of Behavioral Science, Regents of the University of Colorado,

http://www.Colorado.EDU/cspv/blueprints/promise/FDRP.htm)

The Syracuse Family Development Research Program, developed by Dr. J.R. Lally, bolsters child and family functioning and affective, interpersonal relationships through home visitations, parent training and individualized daycare. The intervention targets economically disadvantaged families beginning prior to the birth of the baby and lasting through the preschool years, in order to improve children's cognitive and emotional functioning, foster children's positive outlooks, and decrease juvenile delinquency.

The success of this program is due to its focus on both parents and children. Mothers receive individualized training and support from paraprofessional child development trainers who make weekly home visitations. These trainers help mothers create developmentally appropriate and interactive games for their children, act as liaisons between participants and other support services, foster mothers' involvement in children's educational attainment, and model appropriate interactions with children.

Risk Factors Addressed

Antisocial behavior Academic failure (for girls) Low commitment to school

Protective Factors Addressed

Bonding: Family

CSAP Strategy

Education

Type of Strategy

Selective

Populations Appropriate For This Practice

- Single, young mothers in last trimester of pregnancy
- African Americans
- · Low income

Evaluating This Practice

This practice comes with tools for parents, children, caregivers, and home visitors that can be used when implementing this strategy. Please contact the program for cost information on the evaluation tool.

The following are suggestions of areas you may want to assess if you implement this practice:

- · Assess antisocial behavior, especially juvenile delinquency records
- Assess grades and school attendance
- · Assess higher educational goals
- Assess family unity

Research Conclusions

(Excerpt reprinted with permission from the Center for the Study and Prevention of Violence, Institute of Behavioral Science, Regents of the University of Colorado, http://www.Colorado.EDU/cspv/blueprints/promise/FDRP.htm)

The most dramatic effects of the program were found during a ten-year follow-up evaluation, which demonstrated reduced juvenile delinquency and improved school functioning (for girls) including the following results:

- Only 6% of FDRP children, compared to 22% of the control group, had official juvenile delinquent records.
- · Delinquents from the control group had more serious and chronic offenses, including charges for burglary, robbery, physical assault, and sexual assault.
- FDRP girls showed better grades and school attendance in grades 7-8 than controls.
- · Teachers rated program girls as functioning better in selfesteem, feelings towards others, controlling aggression, and overall school achievement.
- Program children rated themselves more positively, had higher educational goals, and believed they could handle problems better than control children.
- FDRP parents were more proud of their children's prosocial attitudes, more actively encouraged their children's success, and rated their family as having more unity than the control group.

Costs as of December 2001 (Subject to Change)

Training Time:

40 hours during 5 days annually every June

Training Costs:

Call Syracuse University Continuing Education at 315. 443.9378 for costs for credit or audit.

Strategy Implementation:

Cost is estimated at \$7000 per child if the entire program with home visitors, quality childcare, and research outcome measurements is included.

Special Considerations

None identified by program developer

Contact Information

For training, technical assistance, and materials contact:

Dr. Alice S. Honig Syracuse Family Development Research Program (FDRP)

201 Slocum Hall Syracuse University Syracuse, NY 13244

E-mail: ahonig@mailbox.syr.edu

Phone: 315.443.4296 Fax: 315.443.9402

BEST PRACTICE: Tobacco-Free Environment Policies

Description of Best Practice

(Excerpt from Reducing Tobacco Use Among Youth: Community-Based Approaches: A Guideline for Prevention Practitioners. Center for Substance Abuse Prevention, 1997, Prevention Enhancement Protocols Systems Series 1, pp. 21-22.)

The primary goal of tobacco-free environmental policies is to create environments that do not expose youth to the use and possession of tobacco.

Research demonstrates that tobacco use and exposure to secondhand tobacco smoke is a threat to health. Policies restricting the use of tobacco in schools and other environments should reduce adolescents' exposure to secondhand tobacco smoke and limit places where they can use tobacco and, thus, reduce the health risks associated with tobacco use and secondhand smoke.

Activities

- · Review existing laws and compliance with laws restricting tobacco use in certain settings
- Review the effects of antismoking school policies on adolescent smoking
- · Provide technical assistance and guidance on developing and implementing tobacco-free policies and environments
- Educate and inform concerned parties about laws restricting tobacco use in certain settings

Risk Factors Addressed

Community laws and norms favorable toward drug use

Protective Factors Addressed

Healthy beliefs and clear standards

CSAP Strategy

Environmental

Type of Strategy

Universal

Populations Appropriate for This Best Practice

No specific populations

Evaluating This Best Practice

The following are suggested areas to assess when implementing this practice:

- · Assess establishment of policies restricting or prohibiting tobacco use
- · Assess rates of adolescent smoking

Research Conclusions

(Excerpt from Reducing Tobacco Use Among Youth: Community-Based Approaches: A Guideline for Prevention Practitioners, Center for Substance Abuse Prevention, 1997, Prevention Enhancement Protocols Systems Series 1, pp. 21-22.)

The research and practice evidence reviewed indicates that it is possible to implement policies restricting tobacco use in schools and child day-care centers. There is medium evidence that it is possible to influence organizations to develop policies restricting the use, possession, and exposure to tobacco smoke by adolescents and adults. Because changes in policies regarding smoking are relatively recent, it is difficult to determine the ultimate effects of these changes on adolescent tobacco use.

Lessons Learned from Reviewed Evidence

- The establishment of smoking regulations can be accomplished through a variety of mechanisms, including state and local laws, and policies at businesses, schools, and child-care centers.
- Comprehensive policies can decrease prevalence rates, especially when their emphasis is on prevention and cessation.
- · Harsh penalties for the possession of tobacco products by minors, such as suspension from school, may be ineffective interventions for enhancing the enforcement of antismoking regulations or for preventing or decreasing adolescent tobacco use.
- · Instead, programs that provide prevention or cessation services, such as tobacco education courses, tobacco cessation programs, or diversion alternatives, may be most effective.

Costs and Special Considerations

Not available

Contact Information

For more information on this best practice, order a free copy of the following publications from SAMHSA's National Clearinghouse for Alcohol and Drug Information (NCADI) at:

Toll free: 800.729.6686

Reducing Tobacco Use Among Youth: Community-Based Approaches, Center for Substance Abuse Prevention, 1997, Prevention Enhancement Protocols Systems Series 1, publication order no. "PHD 744" (for 12-page community guide); "PHD 745" (for prevention practitioners guide); and "PHD 746" (full document).

BEST PRACTICE: Treatment Foster Care Program

(Chamberlain and Reid)

Description of Best Practice

Oregon Social Learning Center's (OSLC) Multidimensional Treatment Foster Care (MTFC) Program was developed in the early 1980s as an alternative to institutional, residential, and group care placements for youths with severe and chronic criminal behavior. Subsequently, the MTFC model has been adapted for and tested with children and adolescents from the state mental hospital and with youth in statesupported foster care. In addition, three randomized trials are currently underway to test the effectiveness of MTFC in treating chronically delinquent female youth, in treating and preventing emotional and behavioral problems in preschool children, and to test the effectiveness of applying an adaptation of MTFC in a large urban child welfare system. MTFC is also being used to treat developmentally delayed youth with sexual acting-out behaviors and multiple placement failures, and to treat youth who have been referred from managed care mental health systems who are in need of out-ofhome care. Empirical examination of MTFC as applied to these two populations is currently being planned.

Program Objectives

There are two major aims of MTFC - to create opportunities with intensive support so that youths are able to successfully live in the community while simultaneously preparing their parents, relatives, or other aftercare resources to provide effective parenting skills that will increase the chance of a positive reintegration into the family setting and will encourage the maintenance of gains made in MTFC with the ultimate goal of long-term success in the community (i.e., reduction in delinquency, improvements in school functioning and prosocial involvement with peers, family and community). Four key elements of treatment are targeted during placement and aftercare:

- 1) providing youths with a consistent reinforcing environment where he or she is mentored and encouraged
- 2) providing daily structure with clear expectations and limits, as well as well-specified consequences delivered in a teaching-oriented manner
- 3) providing close supervision of youths' whereabouts
- 4) avoiding deviant peer associations while providing support and assistance in establishing pro-social peer contacts

Program Strategies

Placements in MTFC are typically 6-9 months and rely on intensive, well coordinated, multi-method interventions (e.g., family and individual therapy, skill training, academic support, case management) that are implemented across multiple settings (e.g., home, school, community). Involvement of each youth's family or aftercare resource is emphasized from the outset of treatment in an effort to maximize training and preparation for post-treatment care for youths and their families. Progress is tracked through daily phone calls with treatment foster parents where data is collected

on behaviors across home, school and community settings in an effort to aid in the timing, design, and implementation of interventions.

Recruitment and Retention

Referrals are received from state juvenile courts, parole and probation officers, and caseworkers from the Department of Human Services.

Staffing

Case managers are trained in the social learning treatment model and developmental psychopathology, and are responsible for coordinating all aspects of the treatment program. They serve as consultants to the foster parents, provide support and supervision in the form of weekly meetings and daily telephone contact, and are available to the foster parents for support, consultation, and backup 24 hours a day. Foster parents are screened, selected, and trained in a twentyhour pre-service training conducted by staff and an experienced MTFC foster parent. Foster parents are supervised and supported throughout treatment through daily telephone calls and weekly foster parent groups conducted by the case manager.

Special Characteristics

Involvement of the biological family or aftercare resource is emphasized throughout treatment. Families are taught parenting skills to be practiced during home visits and are provided with 24-hour backup and consultation by the family therapist and case manager. Respite care is provided by MTFC foster parents and is coordinated by the case manager.

Comments on Implementation/Replication

In an effort to maintain the least restrictive treatment environment possible, in-home crisis family preservation programs are recommended prior to out-of-home placements (e.g., TFC) for youth with behavioral and emotional difficulties. In particular, Functional Family Therapy or Structural Family Therapy may be used in conjunction with the behavior management strategies utilized in MTFC to create a structured treatment environment in the home setting.

OSLC's MTFC program has been selected as a Blueprint Program for Violence Prevention by the Center for the Study and Prevention of Violence at the University of Colorado at Boulder, and replication under the Blueprint Program is currently underway at two sites. In addition, a randomized study is currently underway to test the effectiveness of applying an adaptation of MTFC in a large urban child welfare system. Consultation to TFC programs across the United States has resulted in the program founder establishing a separate organization, TFC Consultants, that is focused solely on effective dissemination and replication of OSLC's MTFC model.

Risk Factors Addressed

Family management problems Persistent antisocial behavior

Protective Factors Addressed

Pro-social skills

CSAP Strategy

Information dissemination Education

Type of Strategy

Indicated

Populations Appropriate for This Best Practice

- 12- to18-year-olds who have been committed to State Training Schools or who are at risk of commitment because of delinquency
- Foster parents of the above adolescents
- Natural parents of the above adolescents

Evaluating This Best Practice

This best practice comes with an evaluation tool that can be used when implementing this strategy. Cost is dependant upon organization size, i.e., how many youth and foster family are participating.

The following are suggested areas to assess when implementing this practice:

- Assess the increase in family management skills by natural parents and foster parents.
- Assess reduction of delinquency and increase in their prosocial skills and behavior.
- Assess improvements in school attendance and comple-
- · Assess improved adjustment in the community

Research Conclusions

(Excerpt from Treatment Foster Care materials.)

MTFC appears to be an effective and viable method of preventing the placement of youth in more restrictive settings. Evidence suggests that MTFC can prevent escalation of problem behaviors and that MTFC is both more economical and more effective than group care at decreasing incarceration rates post-treatment (Chamberlain, 1990). Overall, MTFC has been shown to be effective in the treatment of adolescents with conduct disorders (Chamberlain, 1996), in the treatment of children and adolescents from a state mental hospital (Chamberlain & Reid, 1991), in the treatment of youth committed to state training schools (Chamberlain & Reid, 1998), and in the treatment of chronic male and female delinquent youth (Chamberlain & Reid, 1998). In addition, specific treatment components (i.e., supervision, discipline, decreased association with delinquent peers, positive adult-youth relationship) have been shown to mediate the treatment effect of MTFC (Eddy & Chamberlain, 2000).

Costs as of December 2001 (Subject to Change)

Training Time:

The course of training is approximately one year, during which organizational readiness is addressed, program staff is trained, and foster parents are recruited, certified and trained. Weekly telephone and video consultation is provided to review program implementation and individual case consultation, and treatment outcomes are reviewed after six months of operation.

Training Cost:

Cost is approximately \$35,000 plus travel and lodging expenses for on-site training of program staff for the start-up of a 10 to 12 bed program. It is also recommended that potential program staff spend several days observing and training at the OSLC MTFC site.

Strategy Implementation:

The funding rate for the Juvenile Justice programs is approximately \$115 per youth per day.

Special Considerations

Please consider the following before selecting this strategy for your community:

· Are personnel available who are trained in the approach?

Contact Information

For more information, training, technical assistance, materials contact:

Gerard Bouwman **TFC Consultants** 160 E. 4th Avenue Eugene, OR 97401

E-mail: gerryb@oslc.org 541.485.2711 Phone: Web site: http://www.oslc.org

For a copy of a summary of the "Blueprint" (step-by-step instructions that will help communities plan and implement youth crime and violence prevention strategies) for this program, Cost: \$15 per copy, visit:

Web site: http://www.colorado.edu/cspv/blueprints

or contact:

Center for the Study and Prevention of Violence

Institute of Behavioral Science University of Colorado at Boulder

Campus Box 442 Boulder, CO 80309-0442 Phone: 303.492.8465

BEST PRACTICE: Tutoring

Description of Best Practice

Academic tutoring has been found to be effective in improving reading and math achievement for socially rejected, low-achieving fourth graders (Hawkins et al, 1992). The Office of National Drug Control Policy cited tutoring as an effective substance abuse strategy (*Tips for Prevention Programming*, 1997).

Some of the Best Practices in this book that have tutoring components, include:

- Quantum Opportunities
- CASASTART
- Project PATHE

Please review these programs for information on how to implement an effective tutoring program.

(Hawkins, J.D., Catalano, R.F., and Miller, J.Y.1992. Risk and Protective Factors for Alcohol and Other Drug Problems in Adolescence and Early Adulthood: Implications for Substance Abuse Prevention, *Psychological Bulletin*, Vol. 112, No. 1, 64-105.)

(*Tips for Prevention Programming, Office of National Drug Control Policy, No.1, May 1997.*)

Risk Factors Addressed

Academic failure

Protective Factors Addressed

Skills: Academic

CSAP Strategy

Education

Type of Strategy

Selective

Populations Appropriate for This Best Practice

Low achieving elementary students

Evaluating This Best Practice

The following suggestion is an area you may want to assess if you implement this best practice:

· Assess students' math and reading achievement levels.

Research Conclusions

(Excerpt from *Tips for Prevention Programming*, Office of National Drug Control Policy, May 1997, Edition No. 1, p. 1.)

 Academic mentoring and tutoring strategies are effective in reducing and preventing AOD [alcohol, other drug] use (Crum, Helzer, and Anthony, 1993; Thomas and Hsiu, 1993; Wiebusch, 1994).

Costs and Special Considerations

Not available

Contact Information

None identified at this time

BEST PRACTICE: Zero-Tolerance Laws

Description of Best Practice

(Excerpt from Alcohol Alert, National Institute on Alcohol Abuse and Alcoholism, October 1996, No. 34, p.1, PH 370.)

"Zero-tolerance laws" set maximum blood alcohol concentration (BAC) limits for drivers under 21 to .02 percent or lower.

Risk Factors Addressed

Community laws and norms favorable toward drug use

Protective Factors Addressed

Healthy beliefs and clear standards

CSAP Strategy

Environmental

Type of Strategy

Universal

Populations Appropriate for This Best Practice

Drivers under 21 years old

Evaluating This Best Practice

The following suggestion is an area you may want to assess if you implement this best practice:

Assess reduction in single-vehicle night time fatal crashes among drivers under 21

Research Conclusions

(Excerpt from Alcohol Alert, National Institute on Alcohol Abuse and Alcoholism, October 1996, No. 34, page 1, PH

An analysis of the effect of zero-tolerance laws in the first 12 states enacting them found a 20-percent relative reduction in the proportion of single-vehicle nighttime fatal crashes among drivers under 21, compared with nearby states that did not pass zero-tolerance laws.

Contact Information

For information on how to enact a policy change regarding zero-tolerance, obtain a free hard copy of How to Change Local Policies to Prevent Substance Abuse from:

Join Together 441 Stuart Street, 7th Floor Boston, MA 02116 Phone: 617.437.1500

Fax:

617.437.9394 Web site: www.jointogether.org



Promising Practices

PROMISING PRACTICE: Bi-Cultural Competence Skills Approach

Note: This program has been categorized as a "promising" practice. The research done to date on this program does not meet the standards needed to be deemed a "best" prac-

Description of Promising Practice

(Excerpts and summary from: Schinke, et al. (1988). Preventing Substance Abuse Among American-Indian Adolescents: A Bicultural Competence Skills Approach. Journal of Counseling Psychology, 35(1), 87-90.)

The bicultural competence approach encompasses skills that can enable American-Indian people to blend the adaptive values and roles of both the culture in which they were raised and the culture by which they are surrounded. The subjects in this study on the bicultural competence approach were 137 American-Indian adolescents from two western Washington reservation sites. They were recruited from tribal and public schools, and they voluntarily participated.

After pre-testing, subjects were randomly divided by reservation site into prevention and control groups. The prevention group participated in ten group intervention sessions to learn bicultural competence skills. Those in the control group at each site received no preventive intervention.

The intervention groups were led by two American-Indian counselors. Via cognitive and behavioral methods, participants were instructed in and practiced communication, coping, and discrimination skills. Communication skills were introduced with biculturally relevant examples of verbal and nonverbal influences on substance use. For instance, leaders modeled how subjects could turn down offers of tobacco, alcohol, and drugs from their peers without offending their American-Indian and non-American-Indian friends. While the participants practiced communication skills, leaders offered coaching, feedback, and praise.

Coping skills included self-instruction and relaxation to help subjects avoid substance use situations and deal with pressure. Leaders suggested alternatives to tobacco, alcohol, and drug use, and taught subjects to reward themselves for positive decisions and actions.

With culturally meaningful examples, leaders helped participants predict high-risk occasions for substance use. Participants also practiced ways to build networks with friends, family, and tribal members who could nurture and sustain responsible decisions about substance use.

Social networking encompassed school, family and reservation resources. In homework assignments, participants were asked to monitor and support one another's preventive intervention attempts between sessions. Reporting on homework gave the participants the opportunity to discuss social networking and allowed them to integrate communication, coping, and discrimination skills for bicultural competence and substance-abuse prevention.

Risk Factors Addressed

Friends who engage in a problem behavior Favorable attitudes toward problem behavior

Protective Factors Addressed

Healthy beliefs and clear standards Skills: Resistance skills, social competence Bonding

CSAP Strategy

Education

Type of Strategy

Universal

Populations Appropriate for This Promising Practice

Native American

Evaluating This Promising Practice

This practice comes with an evaluation tool that can be used when implementing this strategy.

Evaluation Tool Cost:

Please contact the program for cost information.

The following are suggestions of areas you may want to assess if you implement this promising practice:

- · Assess change in substance use attitudes
- · Assess increase in interactive skills
- Assess change in self-reported use of alcohol, tobacco, and other drugs

Research Conclusions

The participants who received preventive intervention, based on bicultural competence skills, improved more at post-test and 6-month follow-up than did the control subjects on measures of substance-use knowledge, attitudes, and interactive skills, and on self-reported use of smoked and smokeless tobacco, alcohol, marijuana, inhalants and other drugs.

The authors believe that these data lend modest support to a bicultural competence skills intervention approach for preventing substance abuse among American-Indian youth. They asserted that the findings have implications for further research, and that the data in this study must be interpreted cautiously because the subjects were a small sample of the myriad American-Indian and Alaska-Native groups

Costs as of December 2001 (Subject to Change)

Materials Cost: \$190

This includes the program and evaluation materials.

Special Considerations

Please consider the following before selecting this strategy for your community:

- All program materials are packaged in an easy-to-use format.
- Technical assistance is offered for implementing and evaluating the program.
- A CD Rom step-by-step guide to setting-up, implementing and evaluating the program has been developed.

Contact Information

For training, technical assistance, and materials contact:

Shobana Raghupathy Sociometrics Corporation 170 State Street, Suite 260 Los Altos, CA 94022

E-mail: Shobana@socio.com Phone: 650.949.3282 x 209 Fax: 650.949.3299

PROMISING PRACTICE: Birth to Three Program – Make Parenting a Pleasure

Note: This program has been categorized as a "promising" practice. The research done to date on this program does not meet the standards needed to be deemed a "best" prac-

Description of Promising Practice

(Excerpt from materials provided by Birth to Three.)

Birth to Three is designed for a broad range of parents with infants and young children (0-7 years of age). Birth to Three's mission is to strengthen families and promote the well being of children through parent education and support. Programs include:

- First 3 Years Program (for families with infants, one and two year olds)
- Make Parenting a Pleasure (for parents with children age birth to seven who are experiencing a higher level of
- Teen Parent Program (for pregnant and parenting teens and their partners ages 12-21)
- Crecer: To Grow Up (for famlies with children ages birth to five whose primary language is Spanish)
- Healthy Start and Welcome Baby (for first time parents of newborns)

All programs are built on the following assumptions:

- Parenting is the most important and challenging job there
- Parents are their children's first and most important teach-
- There are many right ways to be a parent or a child.
- · Parents are the foundation of the family.
- Getting and giving support is essential for parents.

The original format of Birth to Three, which began in 1978, was to bring together new parents from the same neighborhoods into groups to share their parenting experiences, learn about normal early childhood development, develop a support network, and learn about other community resources available to them. Birth to Three has grown considerably since that time in response to the changing needs and dynamics of the family. However, its philosophy and mission have remained unchanged.

All participants in Birth to Three programs receive the following:

- A subscription to the bimonthly Birth to Three Parenting Newsletter.
- Access to the Parent Resource Telephone "Warmline" during working hours, a community service provided to any local parent who calls.
- · Admission to Birth to Three educational events which are often open to the community for a fee.
- The Birth to Three Resources Poster which is also given to all parents in the community through the hospitals when they give birth.
- · The use of the Parent Resource Room for Playtime for

Parents and Children at scheduled times during the week for parents to bring their children for unstructured play and interaction with other Birth to Three families.

Monthly birthday parties for all Birth to Three babies turning one or two during that time period.

Risk Factors Addressed

Family management problems

Protective Factors Addressed

Bonding: Family

CSAP Strategy

Information dissemination Education

Type of Strategy

Universal Selective

Populations Appropriate for This Promising Practice

- · Parents with infants and young children
- Teen parents
- Pregnant and parenting women in recovery from alcohol and other drug abuse

Evaluating This Promising Practice

This best practice comes with an evaluation tool that can be used when implementing this strategy. The curriculum includes a pre- and post-test developed with assistance from Oregon State University. There is also a mid-course evaluation to help guide parent educators in conducting the class.

Evaluation Tool Cost:

There is no cost as the tool is included in the curriculum.

The following are suggested areas to assess when implementing this practice:

- Assess the increase in family management skills
- Assess the number of suspected child abuse cases

Research Conclusions

The curriculum has been evaluated in two empirical studies and found to have significant effect on the reduction of parenting factors that may lead to child abuse such as parent stress levels, harsh parenting, and increased parents' feelings of competence.

Results include:

- Less parental stress and less stress between partners, as measured by the Parent Stress Index (PSI)
- A decrease in abuse potential, in parental stress, in parenting rigidity, and an increase in unhappiness, as measured by the Child Abuse Potential Inventory (CAPI)

- An increase in parents' sense of efficacy, self-esteem, and satisfaction in their parenting.
- A decrease in inappropriate discipline practices by parents.
- Those parents who scored in the clinical range on having problems with their child(ren) at pretest reported a significant reduction in overreactivity, verbosity, and laxness when interacting with their children after the completion of the MPAP class.

Costs as of January 2002 (Subject to Change)

Training Time:

Two eight-hour days. Longer trainings can be arranged.

Training Cost:

\$2,800.00 plus airfare, hotel, ground transportation, and per diem for 2 trainers.

Note: Training is not required for successful implementation of the Make Parenting A Pleasure program. Each training is limited to 25 participants. Please see *Special Considerations* below.

Strategy Implementation:

The cost of implementing this practice includes the following budget areas: \$899 for curriculum package, staff to implement the program, room or site rental, access to a TV-VCR, a nutritious snack for the group and for children of childcare, supplies such as flip charts, etc. for parents, optional supplies for door prizes or other incentives, childcare costs, if childcare is offered.

Special Considerations

Please consider the following before selecting this strategy for your community:

- Program materials for parents are written at 4th grade level and can be adapted for parents who are non-readers.
- Birth to Three strongly advises that each group leader should adjust the pace, presentation style, and amount of material presented in a session to the individual group.
- Make Parenting A Pleasure groups are offered in schools, churches, community centers, service club and agency sites across the country.
- The critical elements are that the site is accessible, inviting, and comfortable, and that staff is welcoming and non-judgmental.
- Group sessions may be offered in evening or day times.
- MPAP can be adapted to be used for home visitation programs.

Contact Information

For training, technical assistance, and materials visit web site:

http://www.birthto3.org

or contact:

Minalee Saks, Executive Director Birth to Three 86 Centennial Loop Eugene, OR 97401

E-mail: msaks@birthto3.org

birthtothree@birthto3.org

Phone: 541.484.5316 Fax: 541.484.1449

Note: This program has been categorized as a "promising" practice. The research done to date on this program does not meet the standards needed to be deemed a "best" prac-

Description of Promising Practice

(Excerpts from: *Diineegwahshii: A Substance Abuse Prevention Program "Promising Practice,"* Fairbanks Native Association, 1998.)

Diineegwahshii is a substance abuse prevention program targeting Alaska Native girls. The philosophy is based on native culturally values, and uses home visits and case management to strengthen bonds between the adolescent girl and her family and confront profound risk factors facing many Alaska Native girls (e.g. teen pregnancy rate of 20 percent for Alaska Native girls ages 15 to 19; school dropout rate of 12.6 percent; high incidence of sexual and/or physical abuse, substance abuse, runaways).

Home visits teach life skills, cultural awareness, and family management skills to teen girls and their mothers. The program also includes field trips, success ceremonies, and family and community gatherings. More specifically, the program includes:

- Outreach
- Assessment (Risk Assessment; Psychosocial Assessment; Family Assessment)
- Case Management Coordinates allied health/human/ social service opportunities or benefits
- Home Visits Individual skill development, emotional/ social support, educational assistance, other assistance
- Group Training Individual skill development/life skills
- Social Learning Activities/Field Trips
- Success Ceremonies Individual or family ceremonies celebrating accomplishments
- · Family and Community Gatherings
- Transportation to and from all program activities and service referrals

Eighty percent of the girls served are Athabaskan. The remainder are other Alaska Natives or American Indians. Seventy-four percent have lived in a village at some point in their life. The ages range from 10 to 18, with the typical girl being 13 years old. Of the girls, 48% have attended four or more schools. The most prevalent risk factors for participants are being economically disadvantaged, being the child of a substance abuser, and being the victim of physical or sexual abuse or neglect.

Risk Factors Addressed

Family management problems Lack of commitment to school

Protective Factors Addressed

Healthy beliefs and clear standards Bonding: Opportunities, skills and recognition

CSAP Strategy

Education Alternatives

Type of Strategy

Selective

Populations Appropriate for This Promising Practice

Native American girls, ages 10-18 and their families

Evaluating This Promising Practice

The following are suggestions of areas you may want to assess if you implement this promising practice:

- · Assess the rate of school drop-out among participants
- Assess the rate of substance abuse among participants

Research Conclusions

During the program's first four years:

- None of the 77 girls enrolled became pregnant
- Only 2.5 percent dropped out of school
- Substance abuse dropped significantly
- Girls and their parents accomplished important personal goals (e.g., mothers gaining employment, participant returning to school, securing new housing)

Costs and Special Considerations

Please inquire of the contact below.

Contact Information

For materials, training, technical assistance, or more information contact:

Valerie Naquin, M.A. Fairbanks Native Association 605 Hughes Ave Fairbanks, AK 99701-7539

E-mail: fnalife@polarnet.com

Phone: 907.452.1274 Fax: 907.456.6306

PROMISING PRACTICE:

The Early Childhood Substance Abuse Prevention Project

Note: This program has been categorized as a "promising" practice. The research done to date on this program does not meet the standards needed to be deemed a "best" practice.

Description of Promising Practice

This program is not currently available for replication. Revisions are being made to the curricula and new materials are being developed.

The Early Childhood Substance Abuse Prevention Project is a preschool and daycare program which consists of three components:

- 1. "I'm So Glad You Asked" prevention curriculum
- 2. "Cherishing Yourself and Your Child" parenting curriculum
- 3. Work within the community, raising awareness of how substance abuse impacts the family

(Excerpt from "Program Findings Sheet," Center for Substance Abuse Prevention, Division of Knowledge Development and Evaluation – Part of CSAP's *Promising Practices Series*, 1998.)

The "I'm So Glad You Asked" curriculum aims to help children mitigate the risks associated with a substance-abusing family environment. "Cherishing Yourself and Your Child" is a relational parenting curriculum that focuses on building the kind of supports, connections and interactive processes between parents and children that promote healthy physical/psychological growth and learning that create mutually empathetic relationships. The curriculum has six sections with numerous activities that can be used for at least 15 (1.5 hour) sessions or more:

- 1) Parent Needs/Child Needs
- 2) Communicating
- 3) Working Through Difficult Feelings
- 4) Inner Child of The Past
- 5) Discipline vs. Punishment
- 6) Discovering Our Inner Nurturer

Staff were also trained with specialized workshops and conferences on specific issues such as neuro-developmental and behavioral outcomes of drug-affected infants and young children.

Program Objectives

- Increase the resiliency and protective factors in preschool children by increasing their self-esteem, decision-making abilities, communication skills, and factual knowledge of substances
- Increase the parenting knowledge and skills of parents enrolled in drug treatment programs and parents enrolled in a family development program for parents who have committed child abuse.

 Increase effective family functioning and reduce the risk of family substance abuse for the targeted families.

Risk Factors Addressed

Parental attitudes and involvement in drug abuse

Protective Factors Addressed

Skills

Bonding to family

CSAP Strategy

Education

Information dissemination

Type of Strategy

Selective

Populations Appropriate for This Promising

Practice

Children ages 3-5 in preschool setting

Evaluating This Promising Practice

This practice is anticipated to come with an evaluation tool that can be used when implementing this strategy. Please see the contact listed below for cost inquiries.

The following are suggested areas to assess when implementing this practice:

- Assess preschoolers' decision-making skills, communication skills, and knowledge of substances
- Assess parents' knowledge and use of discipline methods and other parenting skills
- · Assess parents' empathy toward their children

Research Conclusions

(Excerpt from "Program Findings Sheet," Center for Substance Abuse Prevention, Division of Knowledge Development and Evaluation – Part of CSAP's *Promising Practices Series*, 1998.)

- ISGYA children exhibited more improvement in the ability to identify unsafe objects, particularly those associated with drugs, than the control group.
- ISGYA children showed significantly more improvement in the ability to correctly identify feeling expressions than the control group, and parents reported improvements by preschoolers in expressing their feelings.
- Changes were noted among parents in moving towards understanding and empathy for their children and in moving from punishment to discipline.

Costs

Training Time for CY&YC curriculum: Two days

Training Cost for CY&YC curriculum:

\$600 plus travel, accommodations, rental car, and food. (Ide-

ally, groups need 6 to 12 participants)

The cost of implementing this strategy is currently undetermined.

Special Considerations

None listed at this time

Contact Information

This program is not currently available for replication. Revisions are being made to the curricula and new materials are being developed.

For information about the CY&YC curriculum, contact:

Jan Hudak 1527 N. Juniper Tacoma, WA 98406

E-mail: ljhudak@earthlink.com

253.756.6817 Phone:

PROMISING PRACTICE: Faith-Based Prevention Model

(Formerly known as "Jackson County Church Coalition")

Note: This program has been categorized as a "promising" practice. The research done to date on this program does not meet the standards needed to be deemed a "best" prac-

Description of Promising Practice

(Excerpt from "Jackson County Alcohol and Other Drug Prevention Partnership," 3H86 SPO 4120 01, Health Promotion Program Initiatives of the Area Agency on Aging for North Florida, Inc., July 30, 1991-April 30, 1997.)

Six rural churches, a part of the Partnership Prevention Program, received funds to develop, implement, and evaluate drug prevention programs for their respective church communities. The Health Advisory Council (HAC), the lead founding partner, worked with each church in planning, implementing, and evaluating their respective programs.

The program planning processes philosophically considered:

- The specific health problem to be addressed
- The target population's lower socioeconomic status
- Program delivery systems that include oral traditions
- Influences of the church
- Reading ability and locus of control of the target clients
- Importance of the family

Also considered were concepts inherent in Rokeach's systems of beliefs, attitudes, values, and self-concept, as well as Becker's (1974) Health Belief Model. Most importantly, children-resiliency concepts as influenced by the family, school, and community (Bernard, 1991) were incorporated.

Representative church leaders and pastors participated in training activities that focused on:

- · Alcohol and other drug knowledge
- Basic community development skills
- Effective utilization of community agencies
- Program planning, implementation, and evaluation skills
- Project assessment/reporting procedures

Training activities were guided by materials and manuals developed by project staff. Three training manuals were designed to provide:

- Guidance on how to develop a church drug prevention program and a drug-free community
- Basic alcohol and other drug prevention suggestions
- How ministers can integrate prevention activities into ongoing church activities

As part of the training processes, each church committee planned a program based on:

- · The demographic characteristics of their church commu-
- Religious, socioeconomic, and community cultural val-
- Respective HAC identified priorities
- Available church and grant resources

Each church committee identified special activities using an action plan/fiscal format. The program differed based on the different church characteristics, philosophy, and target population, but all addressed the areas of:

- · Competition and cooperative activities between and among churches
- Youth recognition for excellence programs
- Mentoring
- Parenting
- Keeping youth successful in school
- Alternatives to alcohol and other drug use
- Peer resistance activities
- Public relations activities
- Intergenerational activities
- Training activities
- After school and summer programs
- Data collection

Risk Factors Addressed

Friends who use

Protective Factors Addressed

Healthy beliefs and clear standards

CSAP Strategy

Information

Education

Alternatives

Type of Strategy

Universal

Populations Appropriate for This Promising Practice

Rural

Church members

African Americans

Evaluating This Promising Practice

This practice comes with an evaluation tool that can be used when implementing this strategy. The cost is minimal, about 75 cents per student. Please contact Faith-Based Prevention Model regarding cost.

The following suggestion is an area you may want to assess if you implement this practice:

Assess the likelihood of youth participants engaging in problem behaviors when their friends do.

Research Conclusions

(Excerpt from Mary S. Sutherland, Charles D. Hale, Gregory J. Harris, Philip Stalls, and David Foulk. Strengthening Rural Youth Resiliency Through the Church, Journal of Health Education-July/August 1997, Volume 28, No.4.)

Children were more likely to:

- · Avoid drinking alcohol
- Stay away from bad situations
- Count on their friends for help when confronting serious problems
- · Less likely to participate when friends "get high"
- · Have healthier self-images
- · Perform better in school

Gender had no effect on responses.

Costs as of December 2001 (Subject to Change)

Training Time: Varies

Training Costs: Negotiable

Implementation manuals and materials are available for \$25 (plus \$5 for shipping/postage) each.

Strategy Implementation:

The cost of implementing this strategy is undetermined as volunteers are widely used for the program. A possible estimate for six churches of 150 members each is \$100,000.

Special Considerations

Please consider the following before selecting this strategy for your community:

 Articles regarding this program should be available at local university libraries. These articles better explain the program. Please contact Mary Sutherland or Gregory Harris for a list of published articles. (See below for contact information.)

The program developers encourage interested individuals to not attempt to develop or implement this model without contacting Dr. Sutherland or Mr. Harris. They will share some free materials with interested projects. Further additional manuals are available for purchase: Ministers Manual, Training Manual, Parenting Manual, Grandparenting Manual.

Contact Information

If interested in ordering materials, please contact Dr. Sutherland or Mr. Harris for further instructions.

For training, technical assistance, and materials contact:

Dr. Mary Sutherland or Gregory J. Harris Area Agency on Aging for North Florida, Inc. Health Promotion Program Initiatives 2639 N. Monroe St., Suite 145B

Tallahasee, FL 32312

E-mail: hppi@nettally.com

msutherl@garnet.acns.fsu.edu

Phone: 850.488.0055 Fax: 850.414.6914

850.922.2420

PROMISING PRACTICE: Families in Action

Note: This program has been categorized as a "promising" practice. The research done to date on this program does not meet the standards needed to be deemed a "best" practice

Description of Promising Practice

(Information from: Pilgrim, C., Abbey, A.; Hendrickson, P.; Lorenz, S. (1998). "Implementation and impact of a family-based substance abuse prevention program in rural communities." *Journal of Primary Prevention*, 18(3), 341-361.) Families In Action is a family-based alcohol, tobacco, and other drug abuse prevention program. It targeted families in eight rural school districts with students entering middle or junior high school.

The goals of the program were to increase:

- Resiliency and protective factors including family cohesion
- · Communication skills
- School attachment
- · Peer attachment
- Appropriate attitudes about alcohol and tobacco use by adolescents

The FIA program offers sessions once a week for six consecutive weeks to parents and youth. Program sessions address:

- · Parent/child communication
- Positive behavior management
- Interpersonal relationships for adolescents
- Factors which promote school success

Both parents and youth are taught similar communication skills. Families In Action focused on involving the community in all stages of its program.

Risk Factors Addressed

Parental attitudes favorable toward drug use Lack of commitment to school Favorable attitudes toward problem behavior

Protective Factors Addressed

Opportunities, skills and recognition Healthy beliefs and clear standards Family bonding School bonding Peer bonding Communication skills

CSAP Strategy

Information dissemination Education

Type of Strategy

Universal

Populations Appropriate for This Promising Practice

Rural

6th grade middle schools students/7th grade junior high students and their parents

Evaluating This Promising Practice

This practice comes with an evaluation tool that can be used when implementing this strategy. This program does not charge for the tool however portions of it may need to be purchased from other developers. Data analysis is not provided.

The following suggestion is an area you may want to assess if you implement this practice:

Assess the following: family cohesion, shared family activities, school attachment and participation, peer attachment, curriculum knowledge, and parents' and students' attitudes toward alcohol and tobacco.

Research Conclusions

(Information from: page 357 of Pilgrim, C., Abbey, A.; Hendrickson, P.; Lorenz, S. (1998). "Implementation and impact of a family-based substance abuse prevention program in rural communities." *Journal of Primary Prevention*, 18(3), 341-361.) The results indicated several positive program findings for students and parents:

- Program participation was more beneficial for boys than for girls.
- Boy graduates had higher school and peer attachment, more appropriate attitudes about alcohol, and believed that alcohol should be consumed at an older age as compared to boy non-participants.
- Parents who graduated from the program reported an increase in activities at their child's school and an increase in talking with counselors as compared to non-participants.
- Some short-term program effects were found for parent graduates only: greater curriculum knowledge, higher family cohesion, and an increase in the age considered appropriate for alcohol consumption.

Costs as of May 2001 (Subject to Change)

See Special Considerations on the next page.

Training Time:

8 to 12 hours, depending upon trainee skills and needs

Training Costs:

\$400 per day plus expenses and materials (for your entire group)

Individual fees for TOT workshop through Active Parenting Publishers:

Toll free: 800.826.0080

Note: Standardized training is available through AuSable Valley CMH or through Active Parenting Publishers (Marietta, Georgia) who published the curriculum and is now including it in their Training of Trainers workshops held in Chicago and Atlanta in July.

Strategy Implementation:

- \$450 Start-up cost from Active Parenting Publishers
- \$1,205 each six-session program for up to 20 (families) participants

This \$1,205 figure includes the following:

- · \$200: Participant handbooks for parents and teens
- \$216: Parent Group Leader, 3 hours/night
- \$432: Teen Group Leader and Co-Leader
- \$207: \$17.25 per sibling child care (if provided) per session, minimum of two
- \$150: Refreshments and other materials

Note: An implementation manual (Checkpoint Parent Education Implementation Manual) is available directly from AuSable Valley CMH. It contains numerous details concerning implementation. Electronic copies are free; hard copies are sold at our cost for copying, handling, and mailing. I will be e-mailing a copy with this survey. At one time we professionally tape-recorded a reading of the Parent Handbook for parents who preferred listening, although the book has since been revised. It is possible for a parent to learn the skills by attending the class and not reading the book. We hold the program in the school in the evening to make a positive connection between the parents and the school environment.

Special Considerations

Please consider the following before selecting this strategy for your community:

- Peggy Hendrickson, program developer and co-author, could be available to train your group at your site. She will tailor the training to meet the needs of your parent and teen group leaders, trainers of trainers, school, or administration organization.
- Active Parenting Publishers provides Training of Trainers events in July or, alternatively, they can send a trainer to your site to train group leaders.

Contact Information

For training, materials, technical assistance, or for more information contact:

Peggy Hendrickson, MA, MSW, ACSW AuSable Valley Community Mental Health Services 1199 W. Harris Ave.

P.O. Box 310 Tawas City, MI 48764

E-mail: phendrickson@voyager.net

Phone: 517.362.8636 Fax: 517.362.7800

PROMISING PRACTICE: Friendly PEERsuasion

Note: This program has been categorized as a "promising" practice. The research done to date on this program does not meet the standards needed to be deemed a "best" practice.

Description of Promising Practice

(Weiss, Lazar, F., and Nicholson, H.J. "Friendly peersuasion against substance use: the girls incorporated model and evaluation" in Valentine, J., DeJong, J., Kennedy, N. Substance Abuse Prevention in Multicultural Communities. Haworth Press, New York, 1998, pp. 7-22. Book available from Haworth Press at 800-HAWORTH, getinfo@haworth.com.)

Girls Incorporated designed Friendly PEERsuasion to help girls of middle school age (generally ages 11 through 14) acquire the knowledge, skills and support systems to avoid substance abuse.

In the first phase of the program, the girls participate in 14 one-hour sessions facilitated by a trained adult leader, involving hands-on, interactive and enjoyable activities such as games, group discussions and role plays. Through these activities, participants learn about the short-term and long-term effects of substance abuse, experience healthy ways to manage stress, learn to recognize media and peer pressure to use drugs, practice skills for making responsible decisions about drug use, and prepare to become peer leaders. Each session focuses on a particular objective while reinforcing skills and knowledge introduced in previous sessions. After completing this core curriculum the participants are certified as peer leaders (PEERsuaders).

In the second phase of the program, small teams of peer leaders use what they have learned in phase 1 and draw on their own experiences and creativity to plan and implement eight to ten short sessions of substance abuse prevention activities for children ages 6 through 10 (PEERsuade-Me's). Working with their adult leaders, they present factual information and model and practice skills, attitudes, and behaviors related to substance abuse prevention.

Friendly PEERsuasion was found to be moderately effective in delaying initial or repeat substance use especially among the younger participants.

The demonstration sites chosen for this program included girls from differing ethnic and racial backgrounds who lived in a variety of high-risk situations. The sites were Girls Incorporated organizations in Rapid City, South Dakota; Pinellas Park, Florida; Birmingham, Alabama; and Worcester, Massachusetts.

Risk Factors Addressed

Early initiation of problem behavior Friends who engage in problem behavior Favorable attitudes toward problem behavior

Protective Factors Addressed

Opportunities, skills and recognition

CSAP Strategy

Education Alternatives

Type of Strategy

Universal

Populations Appropriate for This Promising Practice

African American Caucasian (non-minority) Latina Native American

Evaluating This Promising Practice

This practice comes with an evaluation tool that can be used when implementing this strategy. There is no cost for the evaluation tools, which include some technical assistance.

The following are suggested areas to assess when implementing this practice:

- Assess the rate at which participants smoke cigarettes, drink alcohol, and/or use other drugs
- Assess whether participant leave situations in which peers are using harmful substances

Research Conclusions

(Weiss, Lazar, F., and Nicholson, H.J. Friendly PEERsuasion Against Substance Use: The Girls Incorporated Model and Evaluation in Valentine, J., DeJong, J., Kennedy, N. *Substance Abuse Prevention in Multicultural Communities*. Haworth Press, New York, 1998, pp. 7-22. Book available from Haworth Press at 800-HAWORTH, getinfo@haworth.com.)

- Friendly PEERsuasion appeared effective in delaying initial or repeat substance use among the younger participants.
- Younger participants also were likely to report leaving situations in which friends were using harmful substances.
- Evaluations paralleled other substance abuse prevention programs in finding that continuing reinforcement is necessary, such as providing opportunities for PEERsuaders to use what they have learned to benefit others.

Costs as of December 2001 (Subject to Change)

Training Time: Three days

Training Cost: \$300 plus travel, lodging and meals

Strategy Implementation:

Programs are not sold but are licensed on a yearly basis. Interested organizations should phone the contact listed below

Special Considerations

Please consider the following before selecting this strategy for your community:

• Organizations must be affiliated with or licensed by Girls Incorporated to implement Friendly PEERsuasion.

Contact Information

For more program information, visit:

Web site: http://www.girlsinc.org

or contact:

Sarah Riester National Resource Center 441 W. Michigan Street Indianapolis, IN 46202

E-mail: sriester@girls-inc.org Phone: 317.634.7546 ext. 39 Fax: 317.634.3024 To inquire about training, contact:

Penny Sheppard

E-mail: psheppard@girls-inc.org Phone: 317.634.7546 ext. 22

For information about licensing the program, contact:

Kelly Knowlton Maldia

E-mail: kknowlton@girls-inc.org Phone: 317.634.7546 ext. 33

PROMISING PRACTICE: Growing Healthy

Note: This program has been categorized as a "promising" practice. The research done to date on this program does not meet the standards needed to be deemed a "best" practice.

Description of Promising Practice

(Excerpt from information provided by Elaine M. Gasper, M.Ed., Director of Education, National Center for Health Education, New York, NY.)

With 42 to 53 lessons per year, Growing Healthy addresses ten content areas at each grade level for Kindergarten through Grade Six. Growing Healthy promotes students' self-esteem and decision-making skills, enabling them to adopt healthy, responsible attitudes and behaviors. The program addresses not only the physical, but also the emotional and social dimensions of health, and helps students confront today's most pressing health issues such as substance use and abuse, HIV/AIDS, and violence/injury/abuse.

The Growing Healthy curriculum includes activities for family and community involvement. There is also material on conflict resolution and violence prevention integrated into the curriculum. Growing Healthy may easily be integrated into and may enhance the teaching of science, math, language arts, reading, social studies, music, and art. Additionally, the program may be used to meet the curricular guidelines for these subjects.

Puppets, posters, cassettes, books, videos, and 3-D models are included with the program, as well as curriculum teaching guides and blackline masters for each grade level. The Growing Healthy program requires teacher training for those who teach the program. The Growing Healthy Online Training CD ROM helps educators appreciate the importance of comprehensive school health education and learn how to effectively implement and manage the Growing Healthy curriculum, giving participants the confidence they need to bring the program to life. Teachers explore the Growing Healthy curriculum and are exposed to the wide variety of interactive instructional strategies used within the program.

Risk Factors Addressed

Early first use Favorable attitudes toward drug use

Protective Factors Addressed

Healthy beliefs and clear standards

CSAP Strategy

Information dissemination Education

Type of Strategy

Universal

Populations Appropriate for This Promising Practice

K-6th grade students

Evaluating This Promising Practice

This practice does not come with an evaluation tool that can be used when implementing this strategy.

The following are suggested areas to assess when implementing this practice:

- · Assess number of students beginning to smoke
- Assess student attitudes regarding alcohol, tobacco and other drug use

Research Conclusions

(Excerpt from "Growing Healthy" at web site: http://www.nche.org/ghfinalpg/ghresult.html)

One study, with a sample of 30,000 students across 20 states, analyzed four measures of program effectiveness: overall knowledge, attitudes, practices, and program-specific knowledge. The study concluded that health education is an effective means of helping children to improve their health knowledge and to develop healthy attitudes. It found that SHCP showed the strongest statistically significant effects on overall knowledge, attitudes, and behavior of the programs studied.

One of the most striking behavioral correlates of exposure to Growing Healthy was among 7th graders. Based on self-reports, almost 3 times as many students in a control group began smoking in the first half of the 7th grade, as compared to those students enrolled in Growing Healthy. Further, full implementation and fidelity of program design were found to be important factors in the program's success. Growing Healthy's effectiveness was related to the teacher training and materials allocated to support the program.

A second study, conducted by Richard L. Andrews and David D. Moore found, again, that Growing Healthy has a significant impact on students' knowledge, attitudes, and behaviors. In this 10-year longitudinal study, Growing Healthy students were tracked from kindergarten through 7th grade and were subsequently followed up at grades 9-12.

The study also demonstrated that Growing Healthy students have significantly higher levels of knowledge about health and how to maintain personal health compared to students who had a traditional health curriculum. At 7th and 9th grade, Growing Healthy students reported lower levels of experimentation with smoking or illegal drugs than those who did not use the curriculum. The study also found that the differences in knowledge and attitude toward substance abuse and good health persisted three years out of the class.

Costs as of May 2001 (Subject to Change)

Training Time: Approximately 2-3 hours per grade level

Training Costs: \$120 per teacher

Please Note: Those teaching Growing Healthy at more than one grade level will need to purchase a CD-ROM for each grade being taught.

Strategy Implementation:

- \$174.95 for curriculum guide with blackline masters and glossary
- \$39.95 to \$57.95 per set of teacher support materials
- \$875-\$2,395 for a kit of peripheral materials (videos, books, models, posters, etc.) required for each grade level.
- Training Costs

Note: The cost of the program is based on the number of classrooms implementing Growing Healthy at a particular site. Each teacher is required to have a curriculum guide with blackline masters and glossary and a set of teacher support materials. In addition, a kit of peripheral materials is required for each grade level. Up to four teachers at the same grade level share one kit. Training Costs are separate.

These costs are "up-front." Once implementation begins, there are little to no additional costs associated with Growing Healthy.

Special Considerations

Please consider the following before selecting this strategy for your community:

- A training of trainers is also offered for experienced Growing Healthy teachers who wish to become master trainers and train teachers at their local site. Growing Healthy has been successfully implemented in urban, suburban, and rural areas. The program has been implemented in public, private, and parochial schools, and in schools of different types on American Indian reservations.
- The National Center for Health Education provides ongoing technical assistance to project facilitators, administrators, teachers, and others who implement Growing Healthy at the local level. This technical assistance includes information sharing, technical support for training and program implementation, information and referral, and program enhancement opportunities.

Contact Information

For additional information, visit web site: http://www.nche.org

To order Growing Healthy materials, contact:

Toll free: 800.551.3488

For technical assistance, training and general information contact:

Elaine M. Sheehan, M.Ed., Director of Education National Center for Health Education 72 Spring Street, Suite 208 New York, NY 10012

E-mail: elaine@nche.org Phone: 212.334.9470 x 31 Fax: 212.334.9845

PROMISING PRACTICE: I Can Problem Solve

Note: This program has been categorized as a "promising" practice. The research done to date on this program does not meet the standards needed to be deemed a "best" practice.

Description of Promising Practice

(Excerpt reprinted with permission from the Center for the Study and Prevention of Violence, Institute of Behavioral Science, Regents of the University of Colorado, http://www.Colorado.EDU/cspv/blueprints/promise/ICPS.htm)

The I Can Problem Solve (ICPS) is a school-based intervention that trains children in generating a variety of solutions to interpersonal problems, considering the consequences of these solutions, and recognizing thoughts, feelings, and motives that generate problem situations. By teaching children to think, rather than what to think, the program changes thinking styles and, as a result, enhances children's social adjustment, promotes pro-social behavior, and decreases impulsivity and inhibition.

The program was originally designed for use in nursery school and kindergarten, but it has also been successfully implemented with children in grades 5 and 6. Throughout the intervention, instructors utilize pictures, role-playing, puppets, and group interaction to help develop students' thinking skills, and children's own lives and problems are used as examples when teachers demonstrate problem-solving techniques.

Small groups of 6-10 children receive training for approximately three months. The intervention begins with 10-12 lessons teaching students basic skills and problem-solving language. For example, children learn word concepts such as "not" (e.g., acting or not acting); "some/all" (solutions may succeed with one person but not all); "or" (discovering alternative solutions); "if...then" (learning consequences of actions); and "same/different" (thinking of multiple solutions).

The next 20 lessons focus on identifying one's own feelings and becoming sensitive to others' emotions. Students learn to recognize people's feelings in problem situations and realize that they can influence others' responses. The last 15 lessons utilize role-playing games and dialogue to promote problem-solving skills. Students generate solutions to hypothetical problem situations and consider the possible consequences to their decisions.

Risk Factors Addressed

Early antisocial behavior

Protective Factors Addressed

Skills: Problem solving

CSAP Strategy

Education

Type of Strategy

Selective

Populations Appropriate for This Promising Practice

- Children ages 4-12
- · Low income and middle income
- Urban
- Caucasian, Hispanic, Asian, African American and Native American
- Children with Attention Deficit Hyperactivity Disorder and Asbergers Disorder

Evaluating This Promising Practice

This practice comes with an evaluation tool that can be used when implementing this strategy.

Evaluation Tool Cost: \$31

This figure includes the following options:

- Preschool Interpersonal Problem Solving (PIPS) test, \$17.50
- What Happens Next Game (WHNG) \$8.50
- Behavior Rating Scale \$5.00

Each measure above is optional and separate.

The following are suggested areas to assess when implementing this practice:

- Assess the impulsivity of participants
- Assess the problem-solving skills of participants

Research Conclusions

(Excerpt reprinted with permission from the Center for the Study and Prevention of Violence, Institute of Behavioral Science, Regents of the University of Colorado web site: http://www.Colorado.EDU/cspv/blueprints/promise/ICPS.htm)

An evaluation of ICPS that included nursery and kindergarten students revealed significant benefits for intervention students. Immediately following and one year after the program ended, ICPS children, compared to control students, demonstrated:

- · Less impulsive and inhibited classroom behavior
- · Better problem-solving skills

A five-year study including inner-city, low-income children in nursery school and kindergarten demonstrated that intervention children, compared to control students, had:

 Improved classroom behavior and problem-solving skills, even 3-4 years after the program.

A replication with fifth and sixth grade students found that ICPS children, compared to a control group, demonstrated:

- · More positive, pro-social behaviors
- Healthier relationships with peers
- · Better problem-solving skills

(The following note is an excerpt from "I Can Problem Solve [ICPS] for Schools, Raising A Thinking Child [RATC] for Families Research Summary," Myrna B. Shure, Ph.D.)

Note: All research reported above was conducted with lowincome, primarily African American populations. Research by others nationwide has now replicated the impact of ICPS on a diversity of lower- and middle-income groups, including Caucasian, Hispanic, Asian, and American Indian children, as well as with special needs groups, including Attention Deficit Hyperactivity Disorder and Asbergers Disorder.

Costs as of December 2001 (Subject to Change)

Training Time:

Half-day, full-day, and two-day on-site workshops are avail-

Training Costs: \$1000 per day plus travel and expenses

Training is available for teachers, counselors and other school personnel who work with children ages 4-12.

This on-site training provides:

- 1. An overview
- 2. A participant role play:
 - Lessons
 - Talking with children using the problem solving
- 3. A discussion of implementation issues

Workshops can be presented in a train-the-trainers model or in training the teachers directly. The role of the counselor and others are discussed.

Cost for manuals:

- Preschool \$39.95/each
- Kindergarten/primary grades \$39.95/each
- Intermediate elementary grades \$39.95/each

Manuals are available for purchase at Research Press:

Toll free: 800.519.2707 or

Web site: http://www.researchpress.com

Note: Training can be combined with the curricula Raising a Thinking Child, or as a stand-alone.

Special Considerations

Please consider the following before selecting this strategy for your community:

- · A problem-solving style of talk (ICPS dialoguing), used when real problems arise, is key to impacting the children's behavior. This dialogue style helps the child associate "how they think with what they do."
- This program is best implemented by teachers in their classrooms. Counselors and others who work with individual high-risk children can reinforce ICPS with the dialoguing approach as well.

Contact Information

For more information on I Can Problem Solve training, materials and technical assistance, contact:

Myrna B. Shure, Ph.D.

MCP - Hahnemann University

Clinical and Health Psychology Department

245 N 15th ST, MS 626

Philadelphia, PA 19102-1192

E-mail: mshure@drexel.edu

Phone: 215.762.7205 Fax: 215.762.8625

Manuals are available for purchase at Research Press:

Toll free: 800.519.2707 or

Web site: http://www.researchpress.com

PROMISING PRACTICE: Native American Prevention Project Against AIDS and Substance Abuse

Note: This program has been categorized as a "promising" practice. The research done to date on this program does not meet the standards needed to be deemed a "best" practice

Description of Promising Practice

(Excerpts/summary from Rolf, J., Nansel, T., Baldwin, J., Johnson, J., and Benally, C. "HIV/AIDS and substance abuse prevention in American Indian communities: behavioral and community effects." Unpublished document.)

The Native American Prevention Project Against AIDS and Substance Abuse (NAPPASA) collaborated with several schools throughout northern Arizona and western Washington to develop, implement and evaluate culturally sensitive HIV/AIDS preventive interventions that are linked with alcohol and other drug abuse prevention programs. The NAPPASA school curriculum, for 8th and 9th graders, consisted of a 24-session curricula which addressed multiple issues facing American Indian communities from the perspective of the American Indian experience.

Classroom sessions were designed to build knowledge, acquire and practice prevention skills with peers, and foster new positive peer group norms for preventive communications and behaviors in the context of Native American values. The curriculum covered facts and issues about alcohol and other drug abuse; basic reproductive biology; HIV/AIDS; linking AOD to HIV; sexually transmitted diseases (STD's) and how they are transmitted; how assertive communication skills can prevent unwanted sex, pregnancy and STD's; decision making skills; healthy options, social skills, coping with pressures; and reinforced practice and role plays. Further booster sessions involved activities, community meetings, and showing NAPPASA-produced videos and print media.

Both the 8th and 9th grade curricula were presented to the schools as a package containing a NAPPASA Instructor's Manual (approximately 330 pages) NAPPASA Student's Manual, and 9 to 10 videos. A two-day training is delivered to the instructors selected to implement the curriculum.

Risk Factors Addressed

None specifically addressed

Protective Factors Addressed

Healthy beliefs and clear standards

CSAP Strategy

Education

Type of Strategy

Indicated

Populations Appropriate for This Promising Practice

Native American

Evaluating This Promising Practice

The following suggestion is an area you may want to assess if you implement this practice:

 Assess the rate of alcohol and other drug use by program participants over time compared to a comparable group of non-participants

Research Conclusions

(Excerpts/summary from Rolf, J., Nansel, T., Baldwin, J., Johnson, J., and Benally, C. "HIV/AIDS and substance abuse prevention in American Indian communities: behavioral and community effects." Unpublished document.)

Research was conducted with a total of 3,335 8th and 9th grade student participants in Arizona. Since NAPPASA baseline data showed that many of these students were already involved in high-risk behaviors before the NAPPASA preventive intervention, the NAPPASA outcomes were geared toward decreasing future high-risk use of alcohol and other drugs by those already using regularly, and slowing the normal increase in rates of use by the non-users and light users.

Compared to non-intervention groups, a significantly higher percentage of NAPPASA intervention participants remained in or moved to the lower-risk AOD use category at both 9th and 10th grade follow-up. Among the baseline non-users, the "normal developmental trend toward increased AOD use" was slowed.

Preventive interventions targeting sexual behavior often raise concerns that teaching about this may lead to an increase in sexual activity. However, intervention youth showed greater maintenance of virginity, and lower rates of some types of risky sexual behavior in non-virgins. Among the older non-virgin youth, NAPPASA participants were less likely to have had sex while drunk or high, a particularly risky behavior for transmission of STD's, including HIV.

The NAPPASA students consistently showed a marked increase in their use of family, rules, laws, religion, traditional ways, and community protective influences to help them avoid health-risking behaviors.

More information on the effects of NAPPASA can be found in: Mail, P.D.; Heurtin-Roberts, S.; Martin, S.E.; and Howard, J., eds. "Alcohol use among American Indians: multiple perspectives on a complex problem." National Institute on Alcohol Abuse and Alcoholism Research Monograph No. 37. Bethesda, MD: National Institute on Alcohol Abuse and Alcoholism, in press.

Costs and Special Considerations

Please inquire of the contacts below.

Contact Information

For copies of the curriculum, articles, and other resources contact:

Jon Rolf

Center for Substance Abuse Prevention

Division of Prevention Application and Education

5600 Fishers Lane, Rockwall II, Room 800

Rockville, MD 20857

E-mail: jrolf@samhsa.gov Phone: 301.443.0380 Fax: 301.443.5592

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Fax: 520.523.1600

520.523.0148

PROMISING PRACTICE:

Okiyapi: Devils Lake Sioux Community Partnership Project

Note: This program has been categorized as a "promising" practice. The research done to date on this program does not meet the standards needed to be deemed a "best" practice

Description of Promising Practice

(Excerpts from: Hoggarth, A. D., Myer, B. & Rousey, A. (1996). "Family involvement and federal funding: An effective combination for the reduction of substance abuse in an ethnic minority community." Jamestown College.)

The Devils Lake Sioux Community Partnership Project (Okiyapi) was a 5-year federally funded program that aimed to reduce alcoholism on the Devils Lake (now called Spirit Lake) Sioux Reservation in rural North Dakota.

The major goals of the project were to:

- 1. Establish Family Circle Groups
- 2. Develop a coordinating body to provide community agency networking and a comprehensive substance abuse prevention plan
- 3. Train and certify at least five Native American addiction counselors. (Editors' Note: This goal is not considered a primary prevention activity and in many cases could not be funded with prevention dollars.)

Faced with the common situation of a lack of trained personnel in a disadvantaged, minority community, the coalition spent the first two years laying the groundwork by training community residents in addiction counseling. Although this was not considered part of substance abuse prevention, but rather a training activity, the independent evaluator concluded that the program's final success would not have been possible without including tribal members as the key figures in designing and implementing the entire program.

The project sponsored many workshops attended by a wide range of community members. Some activities targeted substance abuse prevention directly. Others addressed depression, suicide, parenting styles characterized by unrealistic expectations of family life and lack of structure, abuse, and domestic violence. Concern for family involvement was an integral part of the program. Okiyapi staff and coalition members took steps to address potential obstacles to participation in prevention and educational activities by offering activities for a wide range of ages, providing transportation, and involving community members extensively in designing and implementing the activities. Professional staff members from Okiyapi and the coalition served mostly to facilitate and support the decisions made by members of the Family Circle Groups.

The lead institution for the community coalition that the project developed was Little Hoops Community College. Activities conducted by Okiyapi were accomplished in cooperation with other agencies including Family Circle Tipi, Four Winds School, Tate Topa Tribal School, Inter-Agency Health Committee and many others. Two community ac-

tivities that have persisted until the present are the Mothers/Grandmothers Support Group and the UNITY Youth Group.

Risk Factors Addressed

Family management problems
Family conflict
Community laws and norms favorable to drugs
Community disorganization

Protective Factors Addressed

Healthy beliefs and clear standards Bonding: Opportunities, skills and recognition

CSAP Strategy

Community-based process Environmental Education Alternatives

Type of Strategy

Universal

Populations Appropriate for This Promising Practice

Rural

Native American

Evaluating This Promising Practice

The following are suggestions of areas you may want to assess if you implement this practice:

- Assess reported use of alcohol and related problems among youth
- Assess community-wide rate of alcohol-related offenses
- Assess changes in tribal laws regarding alcohol use and abuse
- Assess increase in family management skills among participants

Research Conclusions

At the outset of the program, the prevalence of alcoholism in the community was several times the national average. Unemployment, high school dropout rates, drug abuse, poverty, and crime rates also significantly exceeded the national statistics.

Process and outcome evaluation measures for Okiyapi showed evidence of:

- Strong interagency coordination in all program aspects
- Significant increase in community awareness of the program
- · Extensive family involvement in program activities
- Declines in reported use of alcohol and related problems among youth
- Community-wide decline in alcohol-related offenses
- Changes in tribal law restricting availability of controlled substances

Costs and Special Considerations

Please inquire of the contact below.

Contact Information

For more information contact:

Dr. Ann Maria Rousy Cankdeska Cikana Community College 2111 7th St. #8 Santa Monica, CA 90405

E-mail: DrAnnMaria@aol.com

Phone: 310.717.9089 Fax: 310.396.0785

PROMISING PRACTICE:

PARITY: Promoting Academic Retention for Indian Tribal Youth

Note: This program has been categorized as a "promising" practice. The research done to date on this program does not meet the standards needed to be deemed a "best" practice

Description of Promising Practice

(Information from: An Eagle's View: Sharing Successful American Indian/Alaska Native Alcohol and Other Drug Prevention Programs, by B. Hayne. September 1993. Northwest Regional Educational Laboratory, Western Regional Center for Drug-Free Schools and Communities, Volume 1, pp. 6-7. You can view the document at http://www.nwrac.org/pub/library/e/index.html)

PARITY seeks to reduce dropout rates and bolster resiliency in students. The focus group is Native American and non-Native American students, grades six through twelve, of the Klamath Trinity Joint Unified School District of Northern California. The program serves a population separated by mountainous terrain spread over 1,100 square miles.

The PARITY steering committee restructured the math, science, language arts and social science curriculum to make it more relevant to students. The curriculum has been enriched with Native American social, cultural, and historical contributions to the various disciplines. Faculty members from participating universities meet regularly to discuss instructional methods and content with the following four principles in mind:

- 1. Learn about and respect the student population
- 2. Incorporate its values and interests
- 3. Combine resources to enhance learning
- 4. Maintain high expectations

This approach leads to a greater understanding of the students' surroundings and their relationship to a larger, exciting world of learning. Often this becomes a school without walls as students study outdoors at various locations and with a variety of teachers since cross-institutional exchanges occur regularly. The program collaborates with several community partners.

The importance of institutional support for those staff members involved is reflected in release-time, cross-institutional collaboration, orientation and retreat meetings, professional development activities, and a sharing of both human and physical resources among all partner sites.

The PARITY steering committee meets regularly throughout the year to plan major events including fall orientation, fall retreat, Summer Bridge Enrichment, funding issues, public relations with the communities involved, and monitoring the project's overall structure.

The program cites four key components to success:

1. Cross institutional and community support promoting the common good of assisting students

- 2. Dedication of staff and personnel
- 3. Respect for the students and community
- 4. Involvement of all partner participants as equals

Risk Factors Addressed

Lack of commitment to school Academic failure Transitions and mobility

Protective Factors Addressed

Opportunities, skills and recognition: School bonding

CSAP Strategy

Environmental

Type of Strategy

Universal

Populations Appropriate for This Promising Practice

Rural Native Non-Native

Evaluating This Promising Practice

The following are suggestions of areas you may want to assess if you implement this practice:

- Assess the change in attendance and absentee rates of the participants.
- Assess the change in the grades of the participants.

Research Conclusions

(Information from: An Eagle's View: Sharing Successful American Indian/Alaska Native Alcohol and Other Drug Prevention Programs by B. Hayne. September 1993. Northwest Regional Educational Laboratory, Western Regional Center for Drug-Free Schools and Communities, Volume 1, pp. 6-7. This publication is no longer available.)

Monitoring and evaluating the progress of PARITY included data collection from participating schools and organizations. Attendance and absentee rates, grades and academic performance indicators, and CTBS scores were compiled during fall and spring semesters by an internal evaluator. The internal evaluator assessed retention, grades, absences, and CTBS scores, finding compelling evidence of the program's success in the form of CTBS scores.

The enriched curriculum and a Summer Bridge program have been assessed as the source for improvement of CTBS scores across all areas of testing, especially in science, mathematics, English and reading. These results have led to the curriculum changes being institutionalized.

Costs and Special Considerations

Please inquire of the contact below.

Contact Information

For training, technical assistance, materials or for more information:

Dr. Sheila Anne Webb, Dean College of Education and Professional Studies Jacksonville State University Jacksonville, AL 36265

E-mail: sawebb@jsucc.jsu.edu

Phone: 256.782.8213

PROMISING PRACTICE: Solutions for Families

(Formerly known as: "Families in Focus: Seven Secrets to a Successful Family")

Note: This program has been categorized as a "promising" practice. The research done to date on this program does not meet the standards needed to be deemed a "best" practice

Description of Best Practice

(Excerpt from *Strengthening America's Families: Promising Parenting Strategies for Delinquency Prevention*, Office of Juvenile Justice and Delinquency Prevention, 1993, pp. 51-52. Updated in May 2001 from information provided by the developers.)

Program Origin

Solutions for Families began as result of The Cottage Program International's 15 years of working with families to prevent alcohol, drug abuse, and other behavioral disorders. Its companion program Foco Interno Familiar for Spanish speaking families was translated, adapted, and implemented in Hispanic/Latino populations in the United States and Latin America in 1988.

Program Objectives

The program objectives are to reduce alcohol and drug use and their accompanying behavioral disorders, decrease parental denial, educate parents and youth about the consequences of alcohol and drug use, and encourage participation in health promotion and risk-reduction programs.

Program Strategies

The program involves 24 lessons for in-home application or small group workshops in family skills training. Service providers and volunteers are trained to conduct and maintain these prevention services. Meetings are usually held every week to complete the 24 session program. The family members complete a Family Survey questionnaire which is adapted from the Family Adaptability and Cohesiveness Evaluation Scale (FACES III). Once the Family Survey is completed and charted, it directs the family to a specific activity based on their family needs. The Home Learning Guide contains 24 different family lessons and activities. Families maintain contact with Solutions for Families over several months.

Recruitment and Retention

The families are referred by educational institutions, businesses, religious organizations, agencies, and the general communities where the program operates throughout the United States. The program receives substantial attention from the print and electronic media, attracting large numbers of families to participate in the program. Families who become involved in Solutions for Families tend to complete the training cycle and maintain contact with the program over an extended period.

Staffing

Volunteers and professionals are used for the program. One trainer is required for groups of up to 20. The volunteer trainers are trained in 12 hours of classroom training over two days.

Resources Needed and Materials Used: The Solutions for Families program includes the Home Learning Guide, Family Profile, and assorted charts, lists, and brochures.

Risk Factors Addressed

Family management problems Parental attitudes and involvement Family history of substance abuse

Protective Factors Addressed

Bonding: Family

CSAP Strategy

Information dissemination Education

Type of Strategy

Selective

Populations Appropriate for This Promising Practice

Families whose children are at high risk for alcohol and drug use because of:

- · A family history of alcohol and drug abuse
- · Parental communication problems
- · Family management problems
- Youth problems

Evaluating This Promising Practice

This practice does not come with an evaluation tool that can be used when implementing this strategy.

The following are suggested areas to assess when implementing this practice:

- · Assess the decrease in parental drug-use rate.
- Assess improvements in family management skills.
- · Assess improvements in family cohesion.

Costs as of May 2001 (Subject to Change)

Training Time: Two days

Training Costs:

Travel expenses for one volunteer trainer to instruct a core group of facilitators, plus materials

Strategy Implementation:

\$17.95 per participant. The program requests only that program costs be reimbursed. The \$17.95 per participant figure includes workbooks.

Special Considerations

Please consider the following before selecting this strategy for your community:

 The optimum results of this program are best achieved with in-home presentations. · Volunteer facilitators should be willing to spend several weekly visits with the participating family until they can independently follow through on the weekly lessons and activities.

Research Conclusions

(Excerpt from Strengthening America's Families: Promising Parenting Strategies for Delinquency Prevention, Office of Juvenile Justice and Delinquency Prevention, 1993, p. 52)

Solutions for Families undergoes a complete process and outcome evaluation. The evaluation quantifies the effects of participation. The impact that Solutions for Families has on drug abuse, age of first use, abstinence, and use expectancies are measured. Pre- and post-measurement of family functioning and family satisfaction are considered.

Results show:

- Gains in family functioning and family satisfaction.
- · It is indicated that the program significantly reduces the incidence of alcohol and drug abuse.
- Expectancy scores are also predictive of fewer problems with alcohol and drugs.

Contact Information

For training, materials, technical assistance and more information contact:

Brad Stone

5248 S. Pinemont Drive, Suite C-190

Murray, UT 84123

E-mail: bstone81@ix.netcom.com

Phone: 801.268.6461 Fax: 801.268.6471 Web site: http://www.fww.org

PROMISING PRACTICE: Strengthening Multi-Ethnic Families and Communities: A Violence Prevention Parent Training Program

Note: This program has been categorized as a "promising" practice. The research done to date on this program does not meet the standards needed to be deemed a "best" practice.

Description of Promising Practice

(Excerpt from Department of Health Promotion & Education web site: http://www.strengtheningfamilies.org/html/programs_1999/35_SMEFC.html)

The Strengthening Multi-Ethnic Families and Communities Program is a unique integration of various prevention/intervention strategies geared toward reducing violence against self, the family and the community. The program targets ethnic and culturally diverse parents of children aged 3-18 years who are interested in raising children with a commitment to leading a violence-free, healthy lifestyle.

The program goal is to reduce drug/alcohol use, teen suicide, juvenile delinquency, gang involvement, child abuse, and domestic violence. Short-term objectives are to increase parent sense of competence, positive family/parent/child interactions, positive parent/child relationships, child self-esteem and self-discipline, child social competency skills, and increased parental involvement in community locations: churches, schools, community agencies and other locations. The program consists of twelve 3-hour sessions taught in consecutive weeks.

The curriculum includes five major components:

- · Cultural/Spiritual Focus
- Rites of Passage
- Positive Discipline
- Enhancing Relationships
- · Community Involvement

Parent materials are available in English, Spanish, Vietnamese and Korean. Cambodian, Chinese, Somalian, English UK, and Russian translations are being completed. Facilitator manuals are available in English and Spanish. Child activity supplements also are available.

Risk Factors Addressed

Family management problems Low neighborhood attachment

Protective Factors Addressed

Bonding: Family

CSAP Strategy

Education

Type of Strategy

Universal

Populations Appropriate for This Promising Practice

Parents with children ages 3 - 18
Rural
Urban
Caucasian
African American
Asian/Pacific Islander
Hispanic/Latino
Native American
Russian

Evaluating This Promising Practice

This practice comes with an evaluation tool that can be used when implementing this strategy.

Evaluation Tool Costs:

There is no cost for the evaluation tool. Please contact Strengthening Multi-Ethnic Families and Communities for data analysis cost. The cost is dependant on size of analysis group, types of analysis and depth of report.

The following are suggested areas to assess when implementing this practice:

- Assess the level of family management skills of participants.
- Assess the level of positive parent/child interactions.
- Assess the level of parent involvement in community activities.

Research Conclusions

(Excerpt from Department of Health Promotion & Education Web site http://www.strengtheningfamilies.org/html/programs_1999/35_SMEFC.html)

A pre-post test design had been used to evaluate over 100 parent classes.

- Evaluation data from one report of 22 parent groups (357 Parents) show significant improvements in parent sense of competence, family/parent/child interactions, and child competence and behavior.
- Participation in the program had a direct impact on increasing parent involvement in the areas of "Community Activities," "Political Issues," and "School Involvement."
- Reports show that the program helps with child rearing challenges, promotes family bonding, promotes pride in cultural heritage, promotes community bonding, and reduces life-threatening risks for children.

Costs as of December 2001 (Subject to Change)

Training Time: Five days (40 hours)

Training Cost: \$625

Note: The training encourages participants to examine their own background and values in order to learn a facilitative

approach to working with parents from a variety of ethnic and cultural backgrounds.

Strategy Implementation:

\$17 per participant for parent manual, plus additional costs for items such as child care, refreshments, and transporta-

Special Considerations

Please consider the following before selecting this strategy for your community:

• Culturally sensitive facilitators should choose a location and framework which best meets the needs of the families.

Contact Information

For training materials or for more information, contact: Dr. Marilyn L. Steele, Executive Director Consulting and Clinical Services 1220 South Sierra Bonita Avenue

Los Angeles, CA 90019 E-mail: dr_mls@earthlink.net

Phone: 323.936.0343 Fax: 323.936.7130

PROMISING PRACTICE: Teenage Health Teaching Modules

Note: This program has been categorized as a "promising" practice. The research done to date on this program does not meet the standards needed to be deemed a "best" prac-

Description of Promising Practice

(Excerpt taken from information provided by Education Development Center, Inc., Newton, MA)

Teenage Health Teaching Modules (THTM) is a researchbased comprehensive health curriculum for grades six to 12. It consists of 23 modules that focus on the key skills of:

- Decision making
- Communication
- Goal setting
- Self-assessment
- Risk assessment
- Health advocacy
- Healthy self-management

THTM combines the traditional health content areas with the physical, mental, emotional, and social health tasks that students must address to foster healthy lifestyles.

Each THTM module focuses on one or more important health task and related health decisions. The 23 modules are grouped into three grade levels: 6-8, 9 and 10, and 11 and 12. Each module includes a teacher's guide with detailed instructions for conducting classroom activities and original copies of student handouts and transparencies. The study, which involved almost 5,000 students in schools in seven states, demonstrated that THTM had a positive impact on students' health-related knowledge, attitudes, and behav-

The evaluation of THTM concluded that the curriculum produced positive effects on:

- · Students' health knowledge
- Attitudes
- · Self-reported behaviors

As a comprehensive health curriculum, THTM addresses topics as diverse as:

- Disease prevention and control
- Nutrition and fitness
- Injury and violence prevention
- · Mental and emotional health
- Healthy relationships

Risk Factors Addressed

Favorable attitudes toward drug use

Protective Factors Addressed

- Communication
- **Decision-making**
- Health advocacy
- Self-assessment
- Healthy self-management

CSAP Strategy

Education Information dissemination

Type of Strategy

Universal

Populations Appropriate for This Promising Practice

- Junior high/ middle school
- High school students

Evaluating This Promising Practice

This practice comes with an evaluation tool for selected modules, that can be used when implementing this strategy. It is provided upon request. Evaluation Tool Cost: There is no cost for the tool.

The following are suggested areas to assess when implementing this practice:

- Assess the acquisition of the following skills: communication, decision-making, health advocacy, self-assessment, and healthy self-management.
- Assess participants' attitudes toward alcohol, tobacco, and other drug use.

Research Conclusions

(Excerpt taken from information provided by Education Development Center, Inc., Newton, MA)

A large-scale, immediate post-test evaluation of 5,000 students demonstrated changes in students' knowledge and attitudes and, among senior high students, a decline in reported use of tobacco, alcohol, and other drugs

Costs as of May 2001 (Subject to Change)

Training Cost and Time: varies

EDC has developed a network of certified trainers located in various regions of the country who are available to provide teacher training on THTM. Those interested in training should contact EDC to identify a trainer in their state or region. All financial and logistical arrangements for teacher training are handled by the trainer and the school district.

Special Considerations

None identified

Contact Information

For program information, contact: Yvette Camacho **Education Development Center** 55 Chapel Street Newton, MA 02458

E-mail: ycamacho@edc.org

Phone: 617.618.2308 Fax: 617.244.3436 For training information, contact:

Christine Blaber **Educational Development Center** 55 Chapel Street Newton, MA 02458

E-mail: CBlaber@edc.org Phone: 617.969.7101 ext. 2364

PROMISING PRACTICE: Woodrock Youth Development Program

Note: This program has been categorized as a "promising" practice. The research done to date on this program does not meet the standards needed to be deemed a "best" practice.

Description of Promising Practice

(Excerpt from "Program Findings Sheet," Center for Substance Abuse Prevention, Division of Knowledge Development and Evaluation – Part of CSAP's Promising Practices Series, 1998)

Program components include:

- Conduct weekly human relation classes in school to provide youth with the skills to resist pressure to participate in destructive behaviors.
- Assist parents in supporting their child's educational needs through youth advocates who serve as intermediaries between school personnel and parents.
- Hold monthly meetings between Youth Development Program (YDP) youth advocates and classroom teachers to monitor student progress and provide teachers with insight into student needs.
- Conduct an annual home visit at the beginning of the school year to familiarize parents with the program.
- Conduct workshops that allow parents to come together and exchange parenting strategies and ideas.
- Provide field trips and weekend retreats to program youth.
- Implement after-school clubs designed to develop students' individual talents and interests and build self-esteem and human relation skills.

Risk Factors Addressed

Favorable attitudes toward drug use

Protective Factors Addressed

Opportunities Skills Bonding to school Healthy beliefs and clear standards

CSAP Strategy

Education Information dissemination Alternative activities

Type of Strategy

Universal

Populations Appropriate for This Promising Practice

Multi-ethnic youth, ages 6-14

Evaluating This Promising Practice

The following are suggested areas to assess when implementing this practice:

- Assess favorable attitudes toward drug use and its relationship to attendance at YDP activities.
- Assess the levels of alcohol and other drug use in the participants.
- Assess knowledge of the negative effects of alcohol and other drug use.

Research Conclusions

(Excerpt from "Program Findings Sheet," Center for Substance Abuse Prevention, Division of Knowledge Development and Evaluation – Part of CSAP's Promising Practices Series, 1998.)

There was a significant relationship between increased attendance at YDP activities, lower drug use, and increased positive attitudes toward avoiding drugs and alcohol. Knowledge of the negative effects of drugs and alcohol use were significantly higher for the experimental group. Older students in the experimental group reported significantly reduced levels of alcohol and drug use in the past month compared to the control group.

Contact Information

For technical assistance, training, materials, or more information visit:

Web site: www.woodrock.org

or

Rich Garrett Woodrock, Inc. 1229 Chestnut Street, Suite M-7 Philadelphia, PA 19107

E-mail: wradm@aol.com Phone: 215.231.9810 Fax: 215.231.9815



Appendices

APPENDIX A: CSAP's Model Programs and Effective Programs

The following CSAP Model and Effective Programs are included in this book. For more information on the programs, visit the CSAP web site:

Web site: http://modelprograms.samhsa.gov

or call:

Toll free: 877.773.8546.

Model Programs

Across Ages

All Stars

Athletes Training and Learning to Avoid Steroids (ATLAS)

Baltimore Mastery Learning and Good Behavior Game Interventions

Brief Strategic Family Therapy

CASASTART

Child Development Project

Communities Mobilizing for Change on Alcohol

Creating Lasting Connections

DARE to Be You

Families and Schools Together

Family Effectiveness Training (FET)

Incredible Years (Parent and Children Videotape Series) (Webster-Stratton)

Keep A Clear Mind (KACM)

Life Skills Training Program (LST) (Botvin et al)

Multisystemic Therapy

Nurse-Family Partnership

Preparing for the Drug Free Years

Project ACHIEVE

Project ALERT

Project Northland (Perry) Project Toward No Drug Use Project Toward No Tobacco Use Reconnecting Youth Program (Eggert et al) Residential Student Assistance Program Strengthening Families Program

Effective Programs

The programs listed below are ones that met all the criteria as the model programs identified on the CSAP web site:

Web site: http://modelprograms.samhsa.gov

The only difference is that, for a variety of reasons, these programs are not currently available to be widely disseminated to the general public and professional communities. Hence they are identified as effective rather than model. If and when they are available for national dissemination, their status will be upgraded.

Family Advocacy Network (FAN Club)

Houston Parent-Child Development Program

Parenting (Adolescents) Wisely

Perry Preschool Project - High/Scope Approach

Project STAR: Students Taught Awareness and Resistance

Promoting Alternative Thinking Strategies (PATHS)

SMART Leaders

Social Competence Promotion Program for Young Adolescents

Stopping Teenage Addiction to Tobacco (STAT) Syracuse Family Development Research Program

Treatment Foster Care

APPENDIX B: Practices by CSAP Strategy

CSAP Strategies

Prevention strategies have been categorized in a variety of different ways. SAMSHA/CSAP promotes the following six strategies:

Information dissemination

This strategy provides awareness and knowledge of the nature and extent of substance use, abuse, and addiction and their effects on individuals, families, and communities. It also provides knowledge and awareness of available prevention programs and services. Information dissemination is characterized by one-way communication from the source to the audience, with limited contact between the two.

Note: Information dissemination alone has not been shown to be effective at preventing substance abuse.

Education

This strategy involves two-way communication and is distinguished from the information dissemination strategy by the fact that interaction between the educator/facilitator and the participants is the basis of its activities. Activities under this strategy aim to affect critical life and social skills, including decision-making, refusal skills, critical analysis (e.g., of media messages), and systematic judgment abilities.

Alternatives

This strategy provides for the participation of target populations in activities that exclude substance use. The assumption is that constructive and healthy activities offset the attraction to–or otherwise meet the needs usually filled by–alcohol and drugs and would, therefore, minimize or obviate resort to the latter.

Note: Alternative activities alone have not been shown to be effective at preventing substance abuse.

Problem identification and referral

This strategy aims at identification of those who have indulged illegal/age-inappropriate use of tobacco or alcohol and those individuals who have indulged in the first use of illicit drugs in order to assess if their behavior can be reversed through education. It should be noted, however, that this strategy does not include any activity designed to determine if a person is in need of treatment.

Community-based process

This strategy aims to enhance the ability of the community to more effectively provide prevention and treatment services for substance abuse disorders. Activities in this strategy include organizing, planning, enhancing efficiency and effectiveness of services implementation, inter-agency collaboration, coalition building, and networking.

Environmental

This strategy establishes or changes written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of substance abuse in the general population. This strategy is divided into two subcategories to permit distinction between activities that center on legal and regulatory initiatives and those that relate to the service and action-oriented initiatives.

Information Dissemination

The following practices fall into the category of *Information Dissemination* according to the CSAP strategies.

Best Practices

Across Ages (CSAP demonstration grant #2779)

Adolescent Alcohol Prevention Trial (Donaldson et al)

Adolescent Transitions Program (Dishion et al)

All Stars (Hansen)

Athletes Training and Learning to Avoid Steroids: The ATLAS Program (Goldberg et al)

The Child Development Project (CSAP demonstration grant #2647)

Creating Lasting Connections (CSAP demonstration grant #1279)

Effective Black Parenting (Alvy)

Families and Schools Together (FAST) (McDonald)

Family Advocacy Network and SMART Moves (CSAP demonstration grant #1383)

Family Effectiveness Training (Szapocznik)

Family Therapy (general description)

Focus on Families (Catalano et al)

Functional Family Therapy (Alexander and Person)

Home Visiting

Incredible Years (Parent and Children Videotape Series) (Webster-Stratton)

Life Skills Training Program (Botvin et al)

Multi-Component School-Linked Community Approaches (tobacco specific)

Nurse Family Partnership (Prenatal/Early Infancy Project) (Olds et al)

Nurturing Program (Bavolek)

Parent and Family Skills Training (general description)

Parenting and Family Skills Program: Helping the Noncompliant Child (McMahon and Forehand)

Parenting Skills Program (Guerney)

Parents Who Care

Preparing for the Drug Free Years (Hawkins and Catalano)

Project Northland (Perry)

Project STAR (Students Taught Awareness and Resistance)/Midwestern Prevention Project (Pentz)

Project Towards No Tobacco Use

Residential Student Assistance Program (CSAP demonstration grant #0618)

Seattle Social Development Project (Hawkins et al)

SMART Leaders

Strengthening Families Program

Treatment Foster Care Program (Chamberlain and Reid)

Promising Practices

Birth to Three Program

Early Childhood Substance Abuse Prevention Program

Faith-Based Prevention Model (formerly known as

"Jackson County Church Coalition")

Growing Healthy

Solutions for Families (Boswell)

Teenage Health Teaching Modules

Woodrock Youth Development Program

Education

The following practices fall into the category of *Education* according to the CSAP strategies.

Best Practices

Across Ages (CSAP demonstration grant #2779)

Adolescent Alcohol Prevention Trial (Donaldson et al)

Adolescent Transitions Program (Dishion et al)

All Stars (Hansen)

Athletes Training and Learning to Avoid Steroids: The ATLAS Program (Goldberg et al)

Baltimore Mastery Learning (ML) and Good Behavior Game (GBG) Interventions

Brief Strategic Family Therapy

Bry's Behavioral Monitoring and Reinforcement Program

CEDEN Family Resource Center

Child Development Project (CSAP demonstration grant

Creating Lasting Connections (CSAP demonstration grant #1279)

DARE to be You (CSAP demonstration grant #1397)

Effective Black Parenting (Alvy)

Families and Schools Together (FAST) (McDonald)

Family Advocacy Network and SMART Moves (CSAP demonstration grant #1383)

Family Effectiveness Training (Szapocznik)

Family Therapy (general description)

Focus on Families (Catalano et al)

Functional Family Therapy (Alexander and Parsons)

Healthy Families America

Home Instruction Program for Preschool Youngsters (HIPPY)

Home Visiting

Home-Based Behavioral Systems Family Therapy (Gor-

Houston Parent-Child Development Center

Incredible Years (Parent and Children Videotape Series) (Webster-Stratton)

Keep A Clear Mind

Life Skills Training Program (Botvin et al)

Meld

Multi-Component School-Linked Community Approaches (tobacco specific)

Multisystemic Therapy Program

NICASA Parent Project

Nurturing Program (Bavolek)

Parent and Family Skills Training (general description)

Parenting Adolescents Wisely (Gordon)

Parenting and Family Skills Program: Helping the Noncompliant Child (McMahon and Forehand)

Parenting Skills Program (Guerney)

Parents As Teachers

Parents Who Care

Perry Preschool Project - High/Scope Approach

Preparing for the Drug Free Years (Hawkins and Catalano)

Project ACHIEVE

Project ALERT

Project Northland (Perry)

Project PATHE/Organizational Change in School (Gottfredson)

Project STATUS (Gottfredson)

Project Towards No Drug Abuse

Project Towards No Tobacco Use

Promoting Alternative Thinking Strategies (PATHS)

Quantum Opportunities Program

Raising a Thinking Child: I Can Problem Solve (ICPS) Program for Families (Shure)

Reconnecting Youth Program (Eggert et al)

Residential Student Assistance Program (CSAP demonstration grant #0618)

Seattle Social Development Project (Hawkins et al)

SMART Leaders

Social Competence Promotion Program for Young Adolescents

Strengthening Families Program

Strengthening Families Program: For Parents and Youth 10-14 (Iowa Strengthening Families Project)

Strengthening Hawaii Families

Syracuse Family Development Research Program (FDRP)

Treatment Foster Care Program (Chamberlain and Reid) **Tutoring**

Promising Practices

Bi-cultural Competence Skills Approach (Schinke et al)

Birth to Three Program

Diineegwahshii

Early Childhood Substance Abuse Prevention Program

Faith-Based Prevention Model (formerly known as "Jackson County Church Coalition")

Families in Action

Friendly PEERsuasion

Growing Healthy

I Can Problem Solve (ICPS) (Shure)

Native American Prevention Project Against AIDS and Substance Abuse (Rolf, Nansel, et al)

Okiyapi — Devils Lake Sioux Community Partnership

Solutions for Families (Boswell)

Strengthening Multi-Ethnic Families and Communities (Steele)

Teenage Health Teaching Modules

Woodrock Youth Development Program

Alternatives

The following practices fall into the category of Alternatives according to the CSAP strategies.

Best Practices

Across Ages (CSAP demonstration grant #2779)

CASASTART

Mentoring - Big Brothers/Big Sisters

Project Northland (Perry)

Quantum Opportunities Program

Promising Practices

Diineegwahshii

Faith-Based Prevention Model (formerly known as "Jackson County Church Coalition")

Families in Action

Friendly PEERsuasion

Okiyapi — Devils Lake Sioux Community Partnership Project

Woodrock Youth Development Program

Problem Identification and Referral

The following practices fall into the category of *Problem Identification and Referral* according to the CSAP strategies:

Best Practices

CASASTART

Creating Lasting Connections (CSAP demonstration grant #1279)

Families and Schools Together (FAST) (McDonald)

Healthy Families America

Nurse Family Partnership (Prenatal/Early Infancy Project) (Olds et al)

Reconnecting Youth Program (Eggert et al)

Residential Student Assistance Program (CSAP demonstration grant #0618)

Strengthening Families Program

Community-Based Process

The following practices fall into the category of *Community-Based Process* according to the CSAP strategies.

Best Practices

CASASTART

Child Development Project (CSAP demonstration grant #2647)

Communities That Care (Developmental Research and Programs)

Creating Lasting Connections (CSAP demonstration grant #1279)

Multi-Component School-Linked Community Approaches (tobacco specific)

Nurse Family Partnership (Prenatal/Early Infancy Project) (Olds et al)

Project STAR (Pentz)

Promising Practices

Okiyapi - Devils Lake Sioux Community Partnership Project

Environmental

The following practices fall into the category of *Environmental* according to the CSAP strategies.

Best Practices

Blood Alcohol Concentration Laws

CASASTART

Changing the Conditions of Availability

Changing Hours and Days of Sale

Child Development Project (CSAP demonstration grant #2647)

Communities Mobilizing for Change on Alcohol

Counter-Advertising

Economic Interventions (taxes)

Norms for Behavior and Rule Setting in School (Gottfredson)

Project ACHIEVE

Project BASIS

Project CARE

Project Northland (Perry)

Project PATHE/Organizational Change in School (Gottfredson)

Project STAR (Pentz)

Project STATUS (Gottfredson)

Raising the Minimum Legal Drinking Age

Responsible Beverage Service

Restriction of Advertising and Promotion

Retailer-Directed Interventions (tobacco specific)

Stop Teenage Addiction to Tobacco

Tobacco-Free Environment Policies

Zero-Tolerance Laws

Promising Practices

Okiyapi — Devils Lake Sioux Community Partnership Project

PARITY: Promoting Academic Retention for Indian Tribal Youth

APPENDIX C: Practices by Domain

Listed below are the programs and strategies in this text which have been found to be effective in the domains of community, family, school, and/or individual peer.

Community Domain

Best Practices

Athletes Training and Learning to Avoid Steroids: The ATLAS Program (Goldberg et al)

Blood Alcohol Concentration Laws

CASASTART

Changing the Conditions of Availability

Changing Hours and Days of Sale

Communities Mobilizing for Change on Alcohol

Communities That Care (Developmental Research and Programs)

Counter-Advertising

Economic Interventions (Raising Taxes)

Multi-Component School-Linked Community Approaches (tobacco specific)

Norms for Behavior and Rule Setting in School (Gottfredson)

Nurse Family Partnership (Prenatal/Early Infancy Project) (Olds et al)

Organizational Change in School (Gottfredson)

Perry Preschool Project - High/Scope Approach

Project Northland (Perry)

Project STAR (Students Taught Awareness and Resistance)/Midwestern Prevention Project Pentz)

Quantum Opportunities Program

Raising the Minimum Legal Drinking Age

Responsible Beverage Service

Restriction of Advertising and Promotion

Retailer-Directed Interventions (tobacco specific)

Stop Teenage Addiction to Tobacco

Tobacco-Free Environment Policies

Zero-Tolerance Laws

Promising Practices

Okiyapi - Devils Lake Sioux Community Partnership **Project**

PARITY: Promoting Academic Retention for Indian Tribal

Strengthening Multi-Ethnic Families and Communities (Steele)

Family Domain

Best Practices

Adolescent Transitions Program (Dishion et al)

Athletes Training and Learning to Avoid Steroids: The ATLAS Program (Goldberg et al)

Brief Strategic Family Therapy

CEDEN Family Resource Center

Creating Lasting Connections (CSAP demonstration grant #1279)

DARE to Be You (CSAP demonstration grant #1397)

Effective Black Parenting (Alvy)

Families and Schools Together (FAST) (McDonald)

Family Effectiveness Training (Szapocznik)

Family Therapy (general)

Focus on Families (Catalano et al)

Functional Family Therapy Program (Alexander and Parsons)

Healthy Families America

Home Visiting

Home-Based Behavioral Systems Family Therapy (Gor-

Houston Parent-Child Development Center

Incredible Years (Parent and Children Videotape Series) (Webster-Stratton)

Keep A Clear Mind

Meld

Multi-Component School-Linked Community Approaches (tobacco specific)

Multisystemic Therapy

NICASA Parent Project

Nurse Family Partnership (Prenatal/Early Infancy Project) (Olds et al)

Nurturing Program (Bavolek)

Parent and Family Skills (general)

Parenting (Adolescents) Wisely (Gordon)

Parenting Skills Program (Guerney)

Parents Who Care

Preparing for the Drug Free Years (Hawkins and Catalano)

Raising a Thinking Child: I Can Problem Solve (ICPS) Program for Families (Shure)

Residential Student Assistance Program (CSAP demonstration project #0618)

Seattle Social Development Project (Hawkins et al)

Strengthening Families Program

Strengthening Families Program: For Parents and Youth 10-14 (Iowa Strengthening Families Project)

Strengthening Hawaii Families

Treatment Foster Care Program (Chamberlain and Reid)

Promising Practices

Birth to Three Program

Diineegwahshii

(The) Early Childhood Substance Abuse Prevention **Program**

Families in Action

Okiyapi - Devils Lake Sioux Community Partnership **Project**

Solutions for Families

Strengthening Multi-Ethnic Families and Communities (Steele)

School Domain

Best Practices

Across Ages (CSAP demonstration grant #2779)

Baltimore Mastery Learning (ML) and Good Behavior Game (GBG) Interventions

Bry's Behavioral Monitoring and Reinforcement Program **CASASTART**

(The) Child Development Project (CSAP demonstration grant #2647)

Families and Schools Together (FAST) (McDonald)

Family Effectiveness Training (Szapocznik)

Family Therapy (general)

Functional Family Therapy Program (Alexander and Parsons)

Home Instruction Program for Preschool Youngsters (HIPPY)

Home-Based Behavioral Systems Family Therapy (Gordon)

Houston Parent-Child Development Center

Incredible Years (Parent and Children Videotape Series) (Webster-Stratton)

Mentoring - Big Brothers/Big Sisters

Multisystemic Therapy

Norms for Behavior and Rule Setting in School (Gottfredson)

Parenting Adolescents Wisely (Gordon)

Parenting and Family Skills Program: Helping the Noncompliant Child (McMahon and Forehand)

Parents As Teachers

Parents Who Care

Perry Preschool Project - High/Scope Approach

Preparing for the Drug Free Years (Hawkins and Catalano)

Project ACHIEVE

Project BASIS

Project CARE

Project PATHE/Organizational Change in School (Gottfredson)

Project STATUS (Gottfredson)

Promoting Alternative Thinking Strategies (PATHS)

Quantum Opportunities Program

Reconnecting Youth Program (Eggert et al)

Residential Student Assistance Program (CSAP demonstration project #0618)

Seattle Social Development Project (Hawkins et al)

Social Competence Promotion Program for Young Adolescents

Strengthening Families Program

Syracuse Family Development Research Program (FDRP) Treatment Foster Care Program (Chamberlain and Reid) **Tutoring**

Promising Practices

Diineegwahshii

Families in Action

I Can Problem Solve (ICPS) (Shure)

PARITY: Promoting Academic Retention for Indian Tribal Youth

Individual/Peer Domain

Best Practices

Adolescent Alcohol Prevention Trial (Donaldson et al)

All Stars (Hansen)

Athletes Training and Learning to Avoid Steroids: The ATLAS Program (Goldberg et al)

CASASTART

Counter-Advertising

Creating Lasting Connections (CSAP demonstration grant #1279)

Family Advocacy Network and SMART Moves (CSAP grant #1383)

Healthy Families America

Keep A Clear Mind

Life Skills Training (Botvin et al)

Mentoring - Big Brothers/Big Sisters

Multi-Component School-Linked Community Approaches (tobacco specific)

Nurse Family Partnership (Prenatal/Early Infancy Project) (Olds et al)

Preparing for the Drug Free Years (Hawkins and Catalano)

Project ALERT

Project Northland (Perry)

Project STAR (Pentz)

Project STATUS (Gottfredson)

Project Towards No Drug Abuse

Project Towards No Tobacco Use

Reconnecting Youth Program (Eggert et al)

Seattle Social Development Project

SMART Leaders

Promising Practices

Bi-cultural Competence Skills Approach (Schinke et al)

Faith-Based Prevention Model (formerly known as

"Jackson County Church Coalition")

Families in Action

Friendly PEERsuasion

Growing Healthy

Teenage Health Teaching Modules

Woodrock Youth Development Program

APPENDIX D: Practices by Risk Factor

Listed below are the programs and strategies in this text that have been found to be effective for the following risk factors in the community, family, school, individual/peer domains.

(For more information about risk and protective factors, see the pamphlet Developing Healthy Communities: A Risk and Protective Factor Approach to Preventing Alcohol and Other Drug Abuse. For a copy of this pamphlet, visit web site: http:// www.unr.edu/westcapt/products.html or contact CSAP's Western CAPT toll free at 888.734.7476.

Community Risk Factors

Availability of Drugs

Best Practices

CASASTART

Changing the Conditions of Availability

Changing Hours and Days of Sale

Communities Mobilizing for Change on Alcohol

Economic Interventions (Raising Taxes)

Project Northland (Perry)

Project STAR (Students Taught Awareness and Resistance)/Midwestern Prevention Project (Pentz)

Responsible Beverage Service

Retailer-Directed Interventions (tobacco specific)

Stop Teenage Addiction to Tobacco

Community Laws and Norms Favorable Toward Drug Use

Best Practices

Athletes Training and Learning to Avoid Steroids: The ATLAS Program (Goldberg et al)

Blood Alcohol Concentration Laws

Communities Mobilizing for Change on Alcohol

Communities That Care (Developmental Research and Programs)

Counter-Advertising

Economic Interventions (Raising Taxes)

Multi-Component School-Linked Community Approaches (tobacco specific)

Norms for Behavior and Rule Setting in School (Gottfredson)

Project Northland (Perry)

Project STAR (Students Taught Awareness and Resistance)/Midwestern Prevention Project (Pentz)

Raising the Minimum Legal Drinking Age

Responsible Beverage Service

Restriction of Advertising and Promotion

Retailer-Directed Interventions (tobacco specific)

Stop Teenage Addiction to Tobacco

Tobacco-Free Environment Policies

Zero-Tolerance Laws

Promising Practices

Okiyapi - Devils Lake Sioux Community Partnership **Project**

Transitions and Mobility

Best Practices

Communities That Care (Developmental Research and Programs)

Promising Practices

PARITY: Promoting Academic Retention for Indian Tribal

Low Neighborhood Attachment and Community Disorganization

Best Practices

Communities That Care (Developmental Research and Programs)

Promising Practices

Okiyapi — Devils Lake Sioux Community Partnership

Strengthening Multi-Ethnic Families and Communities (Steele)

Extreme Economic Deprivation

Best Practices

Nurse Family Partnership (Prenatal/Early Infancy Project) (Olds et al)

Perry Preschool Project - High/Scope Approach

Quantum Opportunities Program

Family Risk Factors

Family History of Problem Behavior

Best Practices

Residential Student Assistance Program (CSAP demonstration project #0618)

Strengthening Families Program

Promising Practices

Solutions for Families (Boswell)

Family Management Problems

Best Practices

Adolescent Transitions Program (Dishion et al)

Brief Strategic Family Therapy

CEDEN Family Resource Center

Creating Lasting Connections (CSAP demonstration grant #1279)

DARE to Be You (CSAP demonstration grant #1397)

Effective Black Parenting (Alvy)

Families and Schools Together (FAST) (McDonald)

Family Therapy (general)

Focus on Families (Catalano et al)

Functional Family Therapy Program (Alexander and Parsons)

Healthy Families America

Home Visiting

Home-Based Behavioral Systems Family Therapy (Gordon)

Houston Parent-Child Development Center

Incredible Years (Parent and Children Videotape Series) (Webster-Stratton)

Meld

Multisystemic Therapy Program

NICASA Parent Project

Nurse Family Partnership (Prenatal/Early Infancy Project) (Olds et al)

Nurturing Program (Bavolek)

Parent and Family Skills (general)

Parenting (Adolescents) Wisely (Gordon)

Parenting Skills Program (Guerney)

Parents Who Care

Preparing for the Drug Free Years (Hawkins and Catalano)

Seattle Social Development Project (Hawkins et al)

Strengthening Families Program

Strengthening Families Program: For Parents and Youth 10-14 (Iowa Strengthening Families Project)

Strengthening Hawaii Families

Treatment Foster Care Program (Chamberlain and Reid)

Promising Practices

Birth to Three Program

Diineegwahshii

Okiyapi — Devils Lake Sioux Community Partnership Project

Solutions for Families (Boswell)

Strengthening Multi-Ethnic Families and Communities (Steele)

Family Conflict

Best Practices

Adolescent Transitions Program (Dishion et al)

Brief Strategic Family Therapy

Creating Lasting Connections (CSAP demonstration grant #1279)

Family Effectiveness Training (Szapocznik)

Functional Family Therapy Program (Alexander and Person)

Nurturing Progam (Bavolek)

Parent and Family Skills Training (general description)

Preparing for the Drug Free Years (Hawkins and Catalano)

Strengthening Families Program: For Parents and Youth 10-14 (Iowa Strengthening Families Project)

Strengthening Hawaii Families

Promising Practices

Okiyapi — Devils Lake Sioux Community Partnership Project

Parental Attitudes and Involvement in Drug Use Best Practices

Athletes Training and Learning to Avoid Steroids: The ATLAS Program (Goldberg et al)

Creating Lasting Connections (CSAP demonstration grant #1279)

Families and Schools Together (FAST) (McDonald)

Focus on Families (Catalano et al)

Keep A Clear Mind

Multi-Component School-Linked Community Approaches (tobacco specific)

NICASA Parent Project

Nurse Family Partnership (Prenatal/Early Infancy Project) (Olds et al)

Parent and Family Skills Training (general description)

Parents Who Care

Preparing for the Drug Free Years (Hawkins and Catalano)

Strengthening Families Program

Promising Practices

Early Childhood Substance Abuse Prevention Program

Families in Action

Solutions for Families (Boswell)

School

Early and Persistant Anti-Social Behavior

Best Practices

Baltimore Mastery Learning (ML) and Good Behavior Game (GBG) Interventions

Bry's Behavioral Monitoring and Reinforcement Program CASASTART

Family Effectiveness Training (Szapocznik)

Family Therapy (general description)

Functional Family Therapy Program (Alexander and Parsons)

Home-Based Behavioral Systems Family Therapy (Gordon)

Houston Parent-Child Development Center

Incredible Years (Parent and Children Videotape Series) (Webster-Stratton)

Mentoring - Big Brothers/Big Sisters

Multisystemic Therapy

Parenting Adolescents Wisely (Gordon)

Parenting and Family Skills Program: Helping the Noncompliant Child (McMahon and Forehand)

Parents Who Care

Perry Preschool Project - High/Scope Approach

Project BASIS

Project CARE

Project PATHE/Organization Change in School (Gottfredson)

Project STATUS (Gottfredson)

Promoting Alternative Thinking Strategies (PATHS)

Raising a Thinking Child: I Can Problem Solve (ICPS)
Program for Families (Shure)

Reconnecting Youth Program (Eggert et al)

Residential Student Assistance Program (CSAP demonstration project #0618)

Seattle Social Development Project (Hawkins et al)

Strengthening Families Program

Syracuse Family Development Research Program (FDRP)

Treatment Foster Care Program (Chamberlain and Reid)

Promising Practices

I Can Problem Solve (ICPS) (Shure)

Academic Failure Beginning in Elementary School Best Practices

Baltimore Mastery Learning (ML) and Good Behavior Game (GBG) Interventions

Bry's Behavioral Monitoring and Reinforcement Program

CASASTART

Home Instruction Program for Preschool Youngsters (HIPPY)

Home-Based Behavioral Systems Family Therapy (Gordon)

Houston Parent-Child Development Center

Parents As Teachers

Perry Preschool Project - High/Scope Approach

Project ACHIEVE

Project PATHE/Organization Change in School (Gottfred-

Quantum Opportunities Program

Reconnecting Youth Program (Eggert et al)

Seattle Social Development Project (Hawkins et al)

Syracuse Family Development Research Program (FDRP) Tutoring

Promising Practices

PARITY: Promoting Academic Retention for Indian Tribal

Lack of Commitment to School

Best Practices

Across Ages (CSAP demonstration grant #2779)

Child Development Project (CSAP demonstration grant

Families and Schools Together (FAST) (McDonald)

Mentoring - Big Brothers/Big Sisters

Norms for Behavior and Rule Setting in School (Gottfredson)

Perry Preschool Project - High/Scope Approach

Project ACHIEVE

Project PATHE/Organization Change in School (Gottfredson)

Project STATUS (Gottfredson)

Seattle Social Development Project (Hawkins et al)

Syracuse Family Development Research Program (FDRP)

Promising Practices

Diineegwahshii

Families in Action

PARITY: Promoting Academic Retention for Indian Tribal Youth

Individual/Peer

Alienation/Rebelliousness

Best Practices

Preparing for the Drug Free Years (Hawkins and Catalano)

Friends Involved in a Problem Behavior

Best Practices

Adolescent Alcohol Prevention Trial (Donaldson et al)

Athletes Training and Learning to Avoid Steroids: The ATLAS Program (Goldberg et al)

CASASTART

Life Skills Training (Botvin et al)

Project Northland (Perry)

Project STAR (Pentz)

Project STATUS (Gottfredson)

Reconnecting Youth Program (Eggert et al)

Seattle Social Development Project (Hawkins et al) **SMART Leaders**

Promising Practices

Bi-cultural Competence Skills Approach (Schinke et al) Faith-Based Prevention Model (formerly known as "Jackson County Church Coalition")

Friendly PEERsuasion

Favorable Attitudes Toward the Problem Behavior

The following practices have been shown to impact the risk factor of favorable attitudes toward the problem behavior.

Best Practices

Adolescent Alcohol Prevention Trial (Donaldson et al)

All Stars Program (Hansen)

Athletes Training and Learning to Avoid Steroids: The ATLAS Program (Goldberg et al)

Counter-Advertising

Family Advocacy Network and SMART Moves (CSAP grant #1383)

Keep A Clear Mind

Life Skills Training (Botvin et al)

Multi-Component School-Linked Community Approaches (tobacco specific)

Preparing for the Drug Free Years (Hawkins and Catalano)

Project Northland (Perry)

Project STAR (Pentz)

Project Towards No Drug Abuse

SMART Leaders

Promising Practices

Bi-cultural Competence Skills Approach (Schinke et al)

Families in Action

Friendly PEERsuasion

Growing Healthy

Teenage Health Teaching Modules

Woodrock Youth Development Program

Early Initiation of the Problem Behavior

The following practices have been shown to impact the risk factor of early initiation of the problem behavior.

Best Practices

Creating Lasting Connections (CSAP demonstration grant #1279)

Mentoring - Big Brothers/Big Sisters

Preparing for the Drug Free Years

Project ALERT

Project Northland (Perry)

Project Towards No Tobacco Use

Promising Practices

Friendly PEERsuasion

Growing Healthy

Constitutional Factors

The following best practices have been shown to impact the risk factor of constitutional factors.

Best Practices

Healthy Families America

Nurse Family Partnership (Prenatal/Early Infancy Project) (Olds et al)

APPENDIX E: Practices by Age

Early Childhood

The following practices have been evaluated with children from the birth to 5 age range and have been shown to be effective.

Best Practices

CEDEN Family Resource Center

DARE to Be You (CSAP demonstration grant #1397)

Effective Black Parenting

Families and Schools Together (FAST) (McDonald)

Healthy Families America

Home Instruction Program for Preschool Youngsters (HIPPY)

Home Visiting

Houston Parent-Child Development Center

Incredible Years – Parent and Children Videotape Series (Webster-Stratton)

Meld

NICASA Parent Project

Nurse Family Partnerships (Prenatal/Early Infancy Project)

Nurturing Program (Bavolek)

Parenting and Family Skills Program: Helping the Noncompliant Child (McMahon and Forehand)

Parenting Skills Program (Guerney)

Parents As Teachers

Perry Preschool Project - High/Scope Approach

Project ACHIEVE

Raising a Thinking Child: I Can Problem Solve (ICPS)

Program for Families (Shure)

Syracuse Family Development Research Program (FDRP)

Promising Practices

Birth to Three Program

Early Childhood Substance Abuse Prevention Program

I Can Problem Solve (ICPS) (Shure)

Strengthening Multi-Ethnic Families and Communities (Steele)

Elementary School Age

The following practices have been evaluated with children from Kindergarten to 5th grade (approximately ages 5 to 10 years) as participants and have been shown to be effective.

Best Practices

Adolescent Alcohol Prevention Trial (Donaldson et al)

Baltimore Mastery Learning (ML) and Good Behavior Game (GBG) Interventions

Brief Strategic Family Therapy

CASASTART

Child Development Project (CSAP demonstration grant #2647)

Effective Black Parenting

Families and Schools Together (FAST) (McDonald)

Family Effectiveness Training (Szapocznik)

Functional Family Therapy Program (Alexander and Parsons)

Incredible Years (Parent and Children Videotape Series) (Webster-Stratton)

Keep A Clear Mind

Multi-Component School-Linked Community Approaches (tobacco specific)

NICASA Parent Project

Norms for Behavior and Rule Setting in School (Gottfredson)

Nurturing Program (Bavolek)

Parenting Adolescents Wisely (Gordon)

Parenting and Family Skills Program: Helping the Noncompliant Child (McMahon and Forehand)

Parenting Skills Program (Guerney)

Preparing for the Drug Free Years (Hawkins and Catalano)

Project ACHIEVE

Promoting Alternative Thinking Strategies (PATHS)

Raising a Thinking Child: I Can Problem Solve (ICPS)

Program for Families (Shure)

Seattle Social Development Project (Hawkins et al)

Strengthening Families Program

Strengthening Families Program: For Parents and Youth 10-14 (Iowa Strengthening Families Program)

Strengthening Hawaii Families

Tutoring

Promising Practices

Growing Healthy

I Can Problem Solve

Strengthening Multi-Ethnic Families and Communities (Steele)

Woodrock Youth Development Program

Middle School/Junior High Age

The following practices have been evaluated with youth from the Middle School/Junior High age range (approximately grades 6-8, ages 11 to 13 years) and have been shown to be effective.

Best Practices

Across Ages (CSAP demonstration grant #2779)

Adolescent Alcohol Prevention Trial (Donaldson et al)

Adolescent Transitions Program (Dishion et al)

All Stars (Hansen)

Brief Strategic Family Therapy

Bry's Behavioral Monitoring and Reinforcement Program CASASTART

Creating Lasting Connections (CSAP demonstration grant #1279)

Effective Black Parenting (Alvy)

Families and Schools Together (FAST) (McDonald)

Family Advocacy Network and SMART Moves (CSAP grant #1383)

Functional Family Therapy Program (Alexander and Parsons)

Life Skills Training Program (Botvin et al)

Mentoring - Big Brothers/Big Sisters

Multisystemic Therapy Program

NICASA Parent Project

Norms for Behavior and Rule Setting in School (Gottfredson)

The Nurturing Program (Bavolek)

Parenting Adolescents Wisely (Gordon)

Parenting Skills Program (Guerney)

Parents Who Care

Preparing for the Drug Free Years (Hawkins and Catalano)

Project ACHIEVE

Project ALERT

Project BASIS

Project CARE

Project Northland (Perry)

Project PATHE/Organizational Change in School (Gottfredson)

Project STAR (Students Taught Awareness and Resistance)/Midwestern Prevention Project (Pentz)

Project STATUS (Gottfredson)

Project Towards No Tobacco Use

Social Competence Promotion Program for Young Adolescents

Strengthening Families Program: For Parents and Youth 10-14 (Iowa Strengthening Families Program)

Substance Abuse Resources and Disability Issues (SARDI) Treatment Foster Care Program (Chamberlain and Reid)

Promising Practices

Bi-cultural Competence Skills Approach (Schinke et al)

Diineegwahshii

Families in Action

Friendly PEERsuasion

Native American Prevention Project Against AIDS and Substance Abuse (Rolf, Nansel, et al)

PARITY (Promoting Academic Retention for Indian Tribal Youth)

Strengthening Multi-Ethnic Families and Communities (Steele)

Teenage Health Teaching Modules

Woodrock Youth Development Program

High School Age

The following practices have been evaluated with youth of high school age (approximately grades 9-12, ages 14 to 18 years) and have been shown to be effective.

Best Practices

All Stars (Hansen)

Athletes Training and Learning to Avoid Steroids: The ATLAS Program (Goldberg et al)

Brief Strategic Family Therapy

Communities Mobilizing for Change on Alcohol

Creating Lasting Connections (CSAP demonstration grant #1279)

Family Advocacy Network and SMART Moves (CSAP grant #1383)

Functional Family Therapy Program (Alexander and Parsons)

Home-Based Behavioral Systems Family Therapy (Gordon)

Mentoring - Big Brothers/Big Sisters

Multi-Component School-Linked Community Approaches (tobacco specific)

Multisystemic Therapy Program

NICASA Parent Project

(The) Nurturing Program (Bavolek)

Parenting Adolescents Wisely (Gordon)

Parents Who Care

Project PATHE/Organizational Change in School

(Gottfredson)

Project STATUS (Gottfredson)

Project Towards No Drug Abuse

Quantum Opportunities Program

Raising the Minimum Legal Drinking Age

Reconnecting Youth Program (Eggert et al)

Residential Student Assistance Program (CSAP demonstration project #0618)

SMART Leaders

Stop Teenage Addiction to Tobacco

Treatment Foster Care Program (Chamberlain and Reid)

Zero-Tolerance Laws

Promising Practices

Bi-cultural Competence Skills Approach (Schinke et al)

Diineegwahshii

Native American Prevention Project Against AIDS and Substance Abuse (Rolf, Nansel, et al)

PARITY (Promoting Academic Retention for Indian Tribal Youth)

Strengthening Multi-Ethnic Families and Communities (Steele)

Teenage Health Teaching Modules

18- to 20-Year-Old Youth

The following practices have been evaluated with youth past high school age range (approximately ages 19 years and up) and have been shown to be effective.

Best Practices

Communities Mobilizing for Change on Alcohol Raising the Minimum Legal Drinking Age

Zero-Tolerance Laws

Children and Youth with Special Needs (Varied Ages)

The following practices have been evaluated with children with special needs and have been shown to be effective.

Best Practices

CEDEN Family Resource Center

Incredible Years (Parent and Children Videotape Series) (Webster-Stratton)

Meld

Parenting and Family Skills Program: Helping the Noncompliant Child (McMahon and Forehand)

Promoting Alternative Thinking Strategies (PATHS)

Raising a Thinking Child: I Can Problem Solve (ICPS)

Program for Families (Shure)

Promising Practices

I Can Problem Solve (ICPS) (Shure)

APPENDIX F: Practices by Ethnicity

African American

The following practices have been evaluated with African American participants and have been shown to be effective.

Best Practices

Across Ages

Brief Strategic Family Therapy

CASASTART

Effective Black Parenting (Alvy)

Families and Schools Together (FAST) (McDonald)

Family Advocacy Network and SMART Moves (CSAP demonstration grant #1383)

Family Effectiveness Training (Szapocznik)

Home Visiting

Home-Based Behavioral Systems Family Therapy (Gordon)

Incredible Years (Parent and Children Videotape Series) (Webster-Stratton)

Life Skills Training Program (Botvin et al)

Meld

Nurturing Program

Perry Preschool Project - High/Scope Approach

Preparing for the Drug Free Years (Hawkins and Catalano)

Project ACHIEVE

Project CARE

Project PATHE/Organization Change in School (Gottfredson)

Project Towards No Drug Abuse

Project Towards No Tobacco Use

Promoting Alternative Thinking Strategies (PATHS)

Raising a Thinking Child: I Can Problem Solve (ICPS) Program for Families (Shure)

Residential Student Assistance Program (CSAP demonstration grant #0618)

SMART Leaders

Social Competence Promotion Program for Young Adolescents

Strengthening Families Program

Syracuse Family Development Research Program (FDRP)

Promising Practices

Faith-Based Prevention Model (formerly known as "Jackson County Church Coalition")

Friendly PEERsuasion

I Can Problem Solve (ICPS) (Shure)

Strengthening Multi-Ethnic Families and Communities (Steele)

Native American

The following practices have been evaluated with Native American participants and have been shown to be effective.

Best Practices

DARE to Be You (CSAP demonstration grant #1397)

Families and Schools Together (FAST) (McDonald)

Preparing for the Drug Free Years (Hawkins and Catalano)

Promising Practices

Bi-cultural Competence Skills Approach (Schinke et al)

Diineegwahshii

Friendly PEERsuasion

I Can Problem Solve (ICPS) (Shure)

Native American Prevention Project Against AIDS and Substance Abuse (Rolf, Nansel, et al)

Okiyapi — Devils Lake Sioux Community Partnership Project

PARITY: Promoting Academic Retention for Indian Tribal Youth

Strengthening Multi-Ethnic Families and Communities (Steele)

Caucasian

The following practices have been evaluated with Caucasian participants and have been shown to be effective.

Best Practices

Across Ages (CSAP demonstration grant #2779)

Adolescent Alcohol Prevention Trial (Donaldson et al)

Adolescent Transitions Program (Dishion et al)

Athletes Training and Learning to Avoid Steroids: The ATLAS Program (Goldberg et al)

Creating Lasting Connections (CSAP demonstration grant #1279)

DARE to Be You (CSAP demonstration grant #1397)

Families and Schools Together

Family Advocacy Network and SMART Moves (CSAP grant #1383)

Focus on Families (Catalano et al)

Functional Family Therapy Program (Alexander and Person)

Home Visiting

Incredible Years (Parent and Children Videotape Series) (Webster-Stratton)

Life Skills Training Program (Botvin et al)

Nurturing Program

Preparing for the Drug Free Years (Hawkins and Catalano)

Project ACHIEVE

Project Northland (Perry)

Project PATHE (Organizational Change in School) (Gottfredson)

Project STAR (Students Taught Awareness and Resistance)/Midwestern Prevention Project (Pentz)

Project Towards No Drug Abuse

Project Towards No Tobacco Use

Promoting Alternative Thinking Strategies (PATHS)

Raising a Thinking Child: I Can Problem Solve (ICPS)

Program for Families (Shure)

Reconnecting Youth Program (Eggert et al)

SMART Leaders

Social Competence Promotion Program for Young Adolescents

Strengthening Families Program

Promising Practices

(The) Early Childhood Substance Abuse Prevention Program

Friendly PEERsuasion

I Can Problem Solve (ICPS) (Shure)

Strengthening Multi-Ethnic Families and Communities (Steele)

Woodrock Youth Development Program

Asian/Pacific Islander

The following practices have been evaluated with Asian/Pacific Islander participants and have been shown to be effective.

Best Practices

Across Ages (CSAP demonstration grant #2779)

Families and Schools Together (FAST) (McDonald)

Incredible Years (Parent and Children Videotape Series) (Webster-Stratton)

Meld

Nurturing Program

Preparing for the Drug Free Years (Hawkins and Catalano)

Project Towards No Drug Abuse

Project Towards No Tobacco Use

Strengthening Families Program

Strengthening Hawaii Families

Promising Practices

I Can Problem Solve (ICPS) (Shure)

Strengthening Multi-Ethnic Families and Communities (Steele)

Hispanic/Latino

The following practices have been evaluated with Hispanic/Latino participants and have been shown to be effective.

Best Practices

Across Ages

Brief Strategic Family Therapy

CASASTART

DARE to Be You (CSAP demonstration grant #1397)

Families and Schools Together (FAST) (McDonald)

Family Advocacy Network and SMART Moves (CSAP demonstration grant #1383)

Family Effectiveness Training (Szapocznik)

Home Visiting

Houston Parent-Child Development Center

Incredible Years (Parent and Children Videotape Series) (Webster-Stratton)

Life Skills Training Program (Botvin et al)

Meld

Nurturing Program

Preparing for the Drug Free Years (Hawkins and Catalano)

Project Towards No Drug Abuse

Project Towards No Tobacco Use

Residential Student Assistance Program (CSAP demonstration grant #0618)

SMART Leaders

Strengthening Families Program

Promising Practices

I Can Problem Solve (ICPS) (Shure)

Friendly PEERsuasion

Strengthening Multi-Ethnic Families and Communities (Steele)

APPENDIX G: Practices for Rural Communities

The following are practices that have been implemented and evaluated with rural communities.

Best Practices

Adolescent Transitions Program (Dishion et al)

All Stars (Hansen)

Creating Lasting Connections

DARE to Be You (CSAP demonstration grant #1397)

Families and Schools Together (FAST) (McDonald)

Home-Based Behavioral Systems Therapy

Iowa Strengthening Families Program/Strengthening Families Program: For Parents and Youth 10-14

Nurse Family Partnership (Prenatal/Early Infancy Project) (Olds et al)

PATHS (Promoting Alternative Thinking Strategies)

Parenting Adolescents Wisely (Gordon)

Parenting and Family Skills Program: Helping the Noncompliant Child (McMahon and Forehand)

Parenting Skills Program (Guerney)

Project ALERT

Project Northland (Perry)

Project PATHE/Organization Change in School (Gottfredson)

Strengthening Hawaii Families

Promising Practices

Families in Action

Faith-Based Prevention Model

Okiyapi — Devils Lake Sioux Community Partnership Project

PARITY: Promoting Academic Retention for Indian Tribal Youth

Strengthening Multi-Ethnic Families and Communities (Steele)

APPENDIX H: Practices by Institute of Medicine Type

Universal

Best Practices

Adolescent Alcohol Prevention Trial (Donaldson et al)

Adolescent Transitions Program (Dishion et al)

All Stars (Hansen)

Athletes Training and Learning to Avoid Steroids: The ATLAS Program (Goldberg et al)

Baltimore Mastery Learning (ML) and Good Behavior Game (GBG) Interventions

Blood Alcohol Concentration Laws

Changing the Conditions of Availability

Changing Hours and Days of Sale

(The) Child Development Project (CSAP demonstration grant #2647)

Communities Mobilizing for Change on Alcohol

Communities That Care (Developmental Research and Programs)

Counter-advertising

DARE To Be You

Economic Interventions (Raising Taxes)

Effective Black Parenting (Alvy)

Home Visiting

Incredible Years (Parent and Children Videotape Series) (Webster-Stratton)

Keep a Clear Mind

Life Skills Training Program (Botvin et al)

Multi-Component School-Linked Community Approaches (tobacco specific)

NICASA Parent Project

Norms for Behavior and Rule Setting in School (Gottfredson)

Parent and Family Skills Training (general description)

Parenting Skills Program (Guerney)

Parents As Teachers

Parents Who Care

Preparing for the Drug Free Years (Hawkins and Catalano)

Project ACHIEVE

Project ALERT

Project BASIS

Project CARE

Project Northland (Perry)

Project PATHE/Organization Change in School (Gottfred-

Project STAR (Students Taught Awareness and Resistance)/Midwestern Prevention Project (Pentz)

Project Towards No Tobacco Use

Promoting Alternative Thinking Strategies (PATHS)

Raising the Minimum Legal Drinking Age

Raising a Thinking Child: I Can Problem Solve (ICPS) Program for Families (Shure)

Responsible Beverage Service

Restriction of Advertising and Promotion

Retailer-Directed Interventions (tobacco specific)

Seattle Social Development Project (Hawkins et al)

Social Competence Promotion Program for Young Adolescents

Stop Teenage Addiction to Tobacco

Strengthening Families Program

Strengthening Families Program: For Parents and Youth 10-14 (Iowa Strengthening Families Project)

SMART Leaders

Tobacco-Free Environment Policies

Zero-Tolerance Laws

Promising Practices

Bi-Cultural Competence Skills Approach

Birth to Three Program

Faith-Based Prevention Model (formerly known as "Jackson County Church Coalition")

Families in Action

Friendly PEERsuasion

Growing Healthy

Okiyapi - Devils Lake Sioux Community Partnership **Project**

PARITY: Promoting Academic Retention for Indian Tribal Youth

Strengthening Multi-Ethnic Families and Communities (Steele)

Teenage Health Teaching Modules

Woodrock Youth Development Program

Selective

Best Practices

Across Ages (CSAP demonstration grant #2779)

Adolescent Transitions Program (Dishion et al)

Baltimore Mastery Learning (ML) and Good Behavior Game (GBG) Interventions

Bry's Behavioral Monitoring and Reinforcement Program **CASASTART**

CEDEN Family Resource Center

Creating Lasting Connections (CSAP demonstration grant #1279)

DARE to be You (CSAP demonstration grant #1397)

Families and Schools Together (FAST) (McDonald)

Family Advocacy Network and SMART Moves (CSAP grant #1383)

Family Effectiveness Training (Szapocznik)

Focus on Families (Catalano et al)

Healthy Families America

Home Instruction Program for Preschool Youngsters (HIPPY)

Houston Parent-Child Development Center

Incredible Years (Parent and Children Videotape Series) (Webster-Stratton)

Mentoring — Big Brothers/Big Sisters

Nurse Family Partnership (Prenatal/Early Infancy Project) (Olds et al)

Nurturing Program (Bavolek)

Parent and Family Skills Training (general description)

Parenting Adolescents Wisely (Gordon)

Parenting and Family Skills Program: Helping the Noncompliant Child (McMahon and Forehand)

Parenting Skills Program (Guerney)

Parents Who Care

Perry Preschool Project - High/Scope Approach

Project ACHIEVE

Project PATHE/Organization Change in School (Gottfredson)

Project STATUS (Gottfredson)

Project Towards No Drug Abuse

Quantum Opportunities Program

Strengthening Families Program

Strengthening Hawaii Families

Syracuse Family Development Research Program (FDRP)

Tutoring

Promising Practices

Birth to Three Program

Diineegwahshii

(The) Early Childhood Substance Abuse Prevention Program

I Can Problem Solve (ICPS) (Shure)

Solutions for Families (Boswell)

Indicated

Best Practices

Adolescent Transitions Program (Dishion et al)

Brief Strategic Family Therapy

CASASTART

Family Therapy (general description)

Functional Family Therapy Program (Alexander and Parsons)

Home-Based Behavioral Systems Family Therapy (Gordon)

Multisystemic Therapy Program

Parent and Family Skills Training (general description)

Project Towards No Drug Abuse

Reconnecting Youth Program (Eggert et al)

Residential Student Assistance Program (CSAP demonstration project #0618)

Strengthening Families Program

Treatment Foster Care Program (Chamberlain and Reid)

Promising Practices

Native American Prevention Project Against AIDS and Substance Abuse (Rolf, Nansel, et al)

APPENDIX I: Unproven Programs

The following are programs and strategies for which multiple research results failed to support program effectiveness for identified problem behaviors. However, they may be used as one component of a comprehensive prevention program.

- Alternative Activities
- Drug Abuse Resistance Education (DARE)
- Information Dissemination/Fear Arousal/Moral Appeal
- Self-Esteem Enhancement Programs

Alternative Activities (e.g., Midnight Basketball, Drug-Free Dances)

(The following is an excerpt from *Selected Findings in Prevention: A Decade of Results from the Center for Substance Abuse Prevention*, Center for Substance Abuse Prevention, 1996, pp. 27-28.)

Recreational and cultural activities, known generically as "alternative activities," often are regarded as attractive enhancements of prevention programs. Community prevention planners sometimes describe such activities, including organized sports and elaborate field trips, as the "hook" that attracts youth participants to community-based prevention programs. The implication is that other activities, such as skills training, are more essential components of prevention programming.

A national cross-site evaluation of community prevention partnerships conducted by CSAP found that alternative activities were cited as the single largest expense for roughly one-third of the partnerships. At least in terms of their relative cost, drug-free recreational and cultural activities often appear to dominate the agenda of community-based substance abuse prevention.

Despite a continuing lack of scientific evidence for their effectiveness, some prevention professionals believe that drugfree recreational and cultural activities that incorporate social skills development and mental health promotion are core elements in the prevention of substance abuse. The Center for Substance Abuse Prevention believes in conducting more focused research to resolve the issue of the appropriate role for alternative activities in the overall prevention agenda.

For more information, order the following free document:

A Review of Alternative Activities and Alternative Programs in Youth-Oriented Prevention, CSAP Technical Report #13, Center for Substance Abuse Prevention, 1996. Order from SAMHSA's National Clearinghouse for Alcohol and Drug Information (NCADI), 800.729.6686, and request publication order no. "PHD 731."

Drug Abuse Resistance Education (DARE)

(The following is an excerpt from *Preventing Crime: What Works, What Doesn't, What's Promising* (1997). Office of Justice Programs and the University of Maryland, Department of Criminology and Criminal Justice, pp. 5-32 to 5-36.)

Summary

Using criteria adopted from the report cited above, D.A.R.E. does not work to reduce substance use. The program's content, teaching methods and use of uniformed police officers rather than teachers might each explain its weak evaluations. No scientific evidence suggests that the D.A.R.E. core curriculum, as originally designed or revised in 1993, will reduce substance use in the absence of continued instruction more focused on social competency development. Any consideration of D.A.R.E.'s potential as a drug prevention strategy should place D.A.R.E. in the context of instructional strategies in general. No instructional program is likely to have a dramatic effect on substance use. Estimates of the effect sizes of even the strongest of these programs are typically in the mid to high teens. D.A.R.E.'s meager effects place it at the bottom of the distribution of effect sizes, but none of the effects are large enough to justify their use as the centerpiece of a drug prevention strategy. Rather, such programs should be embedded within more comprehensive programs using the additional strategies identified elsewhere in this chapter.

In-Depth Review of Evaluations of D.A.R.E.

Several evaluations of the original 17-lesson core have been conducted. Many of these are summarized in a meta-analysis of D.A.R.E.'s short-term effects (Ringwalt et al., 1994) sponsored by NIJ. This study located 18 evaluations of D.A.R.E.'s core curriculum, of which eight met the methodological criterion standards for inclusion in the study.

The study found:

- Short-term effects on drug use, except for tobacco use, were non-significant.
- The sizes of the effects on drug use are slight. Effect sizes average .06 for drug use and never exceed .11 in any study.
 The effects on known risk factors for substance use targeted by the program are also small: .11 for attitudes about drug use and .19 for social skills.
- Certain other programs targeting the same age group as D.A.R.E. upper elementary pupils are more effective than D.A.R.E. "Interactive" programs, which emphasize social skill development and social competencies and use interactive teaching strategies, have effect sizes for increasing social skills, reducing attitudes favorable to use, and reducing drug use at least three times as large as D.A.R.E. Other programs which emphasize knowledge about drugs and affective outcomes (such as self-esteem) and are primarily delivered by an expert are no more effective than D.A.R.E. Note however, that even the more effective programs show only small effect sizes (ES=.18) for reducing drug use.

For more recent reports, three of them longitudinal, have also failed to find positive effects for D.A.R.E. In a reasonably rigorous study of approximately 1,800 students in Sweden, Lindstrom (1996) found no significant differences on measures of delinquency, substance use, or attitudes favor-

ing substance use between students who did and did not receive the D.A.R.E. program. Sigler and Talley (1995) found no difference in the substance use of seventh grade students in Los Alamos, New Mexico who had and had not received the D.A.R.E. program 11 months before.

Rosenbaum, Flewelling, Bailey, Ringwalt, and Wilkinson (1994) report on a study in which 12 pairs of schools (involving nearly 1,600 students) were randomly assigned to receive or not receive D.A.R.E. Although some positive effects of the program were observed immediately following the program, by the next school year no statistically significant differences between the D.A.R.E. and non-D.A.R.E. students were evident on measures of the use of cigarettes or alcohol. Also, only one of 13 intervening variables targeted by the program showed a positive effect.

Clayton, Cattarello, and Johnstone (1996) reported on long-term effects for D.A.R.E. Thirty-one schools were randomly assigned to receive or not receive D.A.R.E. All students in the sixth grades in these schools were tested prior to the program, post-tested shortly after the program, and resurveyed each subsequent year through the tenth grade. Although positive effects were observed during the seventh grade on some risk factors for substance use, no significant differences were observed between the D.A.R.E. and control schools on measures of cigarette, alcohol, or marijuana use either during seventh grade or at any later point.

These studies and recent media reports have criticized D.A.R.E. for:

- a) focusing too little on social competency skill development and too much on affective outcomes and drug knowledge;
- b) relying on lecture and discussion format rather than more interactive teaching methods; and
- using uniformed police officers who are relatively inexperienced teachers and may have less rapport with the students.

To the untrained eye, the content and methods used in D.A.R.E. are not strikingly different from those used in the more effective programs such as Life Skills Training (L.S.T., summarized above) and Social Problem Solving (S.P.S., summarized below). But more subtle differences exist: L.S.T. and S.P.S. provide broader and deeper coverage of more and more practice for students in the development of social competency skills. For example, while all three programs contain lessons on identifying social influences to use drugs and problem solving, the non- D.A.R.E. programs provide more lessons on these topics and also include lessons on communication skills or emotional perspective taking.

Weissberg's S.P.S. program is able to address self-control skills in greater depth because it completely omits lessons on self-esteem and factual information about drugs. The instructional methods are also different: L.S.T. and S.P.S. were carefully designed to make use of cognitive-behavioral methods including frequent role playing, rehearsal of skills, and behavioral modeling. These methods are main features of the programs. D.A.R.E., even with the addition of more "interactive" techniques, lacks a major emphasis on the use of these carefully developed, research-based teaching techniques.

Although the content and method differences described above probably account for some of the discrepancy between the effects found for the different types of instructional programs, the largest difference among the programs is D.A.R.E.'s use of uniformed officers to deliver the program, a feature that remains in the revised D.A.R.E. and whose effects on the efficacy of the program are unknown.

D.A.R.E. proponents challenge the results of the scientific D.A.R.E. evaluations. Officials of D.A.R.E. America are often quoted as saying that the ample public support for the program is a better indicator of its utility than scientific studies. They criticize D.A.R.E. studies for:

- a) looking only at the original D.A.R.E. model;
- b) focusing on the absence of effects on alcohol and drug use among fifth and sixth-graders when the base rates are so low that effects would naturally be difficult to detect; and
- c) failing to study the longer term effects of D.A.R.E. which are expected to be more substantial. Each of these points is addressed below.

In 1993, D.A.R.E. added more coverage of social competency skills and more interactive teaching techniques to its core curriculum (Ringwalt et al., 1994). These changes were expected to bring the program more in line with the competition. No outcome evaluation of this revised curriculum has been reported, but it appears unlikely that the revision will change the results much because the largest difference between the earlier and revised program is the substitution of a single lesson on reducing violence for one on building support systems. Ringwalt et al. (1994) show that even in the revised core curriculum for D.A.R.E., only nine of the 17 lessons cover social skill development.

D.A.R.E. is indeed atypical in its focus on elementary schoolaged youths. As Hansen (1992) demonstrates, the percentage of fifth graders estimated to have used tobacco, alcohol, or marijuana in the past month ranges between about one and eight percent nationally. While lifetime use estimates (the outcome measure often used in D.A.R.E. evaluations) are certainly higher, the relatively low prevalence rates mean that larger samples may be required in studies of D.A.R.E. than in studies of programs targeting slightly older students. But D.A.R.E. evaluations cannot be summarily dismissed on the basis of these criticisms because some have involved samples whose base rates for substance use are much higher than the national average and others have involved samples with sufficient power to detect meaningful differences even in low-base-rate populations. For example, the Rosenbaum et al. (1994) study involved nearly 1,600 students in a sample whose base rate for lifetime alcohol use was 55 percent. Half of the studies summarized in the Ringwalt et al. (1994) study had sample sizes larger than 1,000 and none could be described as small-sample research. Also, the Ringwalt et al. (1994) meta-analysis relied not only on statistical significance tests, which are misleading when the number of cases is not sufficiently large to detect the expected effect, but also on effect sizes to assess the magnitude of the effects regardless of statistical significance. Inferences based on effect sizes are not as prone to misinterpretation as those based on significance levels.

D.A.R.E. proponents also argue that D.A.R.E.'s effects are delayed - i.e., that effects appear when students reach higher grades. The three recent longer-term evaluations of D.A.R.E. (Clayton, Cattarello, and Johnstone, 1996; Sigler and Talley, 1995; Rosenbaum, Flewelling, Bailey, Ringwalt, and Wilkinson, 1994; summarized above) do not support this contention. The absence of long-term effects is not surprising given the more general finding that effects for instructional substance use prevention programs decay rather than increase over time in the absence of continued instruction.

Background on D.A.R.E.

D.A.R.E., developed in 1983 by the Los Angeles Police Department and the Los Angeles Unified School District, is the most frequently used substance abuse education curriculum in the United States. According to D.A.R.E. America (Law Enforcement News, 1996) the program is now used by 70 percent of the Nation's school districts and will reach 25 million students in 1996. About 25,000 police officers are trained to teach D.A.R.E. It is also popular in other countries, 44 of which have D.A.R.E. programs. The complete array of D.A.R.E. activities currently on the market includes "visitation" lessons during which police officers visit students in kindergarten through fourth grade for brief lessons on topics such as obeying laws, personal safety, and the helpful and harmful uses of medicines and drugs; a 17-week core curriculum for fifth or sixth graders (to be described shortly); a 10-week junior high school program focusing on resisting peer pressure, making choices, managing feelings of anger and aggression, and resolving conflicts; and a 10-week senior high program (co-taught with the teacher) on making choices and managing anger. In addition, D.A.R.E. offers an afterschool program for middle-school-aged students, called D.A.R.E. + PLUS (Play and Learn Under Supervision). This provides a variety of fun activities for students during the afterschool hours. Programs for parents and special education populations are also available.

The core 17-lesson curriculum delivered to students in grades five or six has always been the most frequently used form of the program. The great majority (81 percent) of school districts with D.A.R.E. implement the core curriculum, while 33 percent use the visitations, 22 percent the junior high, 6 percent the senior high, and 5 percent the parent curriculum (Ringwalt et al., 1994). The core curriculum is the only part of the program that had undergone rigorous outcome evaluation.

The core D.A.R.E. program is taught by a uniformed law enforcement officer. The original 17-lesson core curriculum focuses on teaching pupils the skills needed to recognize and resist social pressures to use drugs. It also contains lessons about drugs and their consequences, decision-making skills, self-esteem, and alternatives to drugs. Teaching techniques include lectures, group discussions, question-and-answer sessions, audiovisual materials, workbook exercises, and role playing. The curriculum was revised in 1993 to substitute a lesson on conflict resolution and anger management skills for one on building support systems.

For more information on D.A.R.E., see the following:

Lynam, D.R. Milich, R., Zimmerman, R., et al. Project DARE: No effects at 10-year follow-up. Journal of Consulting and Clinical Psychology, Vol. 67, No. 4, 1999, 590-593.

- Hansen, W.B. and McNeal, R.B. How D.A.R.E. works: an examination of program effects on mediating variables. Health Education and Behavior, April 1997, Vol. 24, No. 2,
- Preventing Crime: What Works, What Doesn't, What's Promising. Office of Justice Programs and the University of Maryland, Department of Criminology and Criminal Justice, 1997, http://www.ncjrs.org 800.851.3420.
- Rosenbaum, D.P., Flewelling, R., Bailey, S.L. et al. Cops in the classroom: a longitudinal evaluation of drug abuse resistance education (DARE). Journal of Research in Crime and Delinquency, Vol. 31, No. 1, February 1994, 3-31.
- Ennett, S.T., Rosenbaum, D.P., Flewelling, R.L. et al. Long-Term Evaluation of Drug Abuse Resistance Education, Addictive Behaviors. Vol. 19, No. 2, 1994, 113-125.
- "Past and Future Directions of the DARE Program: An Evaluation Review, Draft Final Report," September 1994, Research Triangle Institute and University of Kentucky. (Found on NCJRS's web-site: http://www.ncjrs.org/txtfiles/ dareev.txt)

Information Dissemination/Fear Arousal/Moral **Appeal**

(The following is an excerpt from Preventing Crime: What Works, What Doesn't, What's Promising (1997). Office of Justice Programs and the University of Maryland, Department of Criminology and Criminal Justice, pp. 5-29.)

Several meta-analyses and reviews of the effectiveness of school-based drug prevention instruction have been conducted (Botvin, 1990; Botvin et al., 1995; Dryfoos, 1990; Durlak, 1995; Hansen, 1992; Hawkins, Arthur, and Catalano, 1995; Institute of Medicine, 1994; Tobler, 1986, 1992). Botvin (1990) traces the historical development of these programs. He shows that "information dissemination" approaches which teach primarily about drugs and their effects, "fear arousal" approaches that emphasize the risks associated with tobacco, alcohol, or drug use, "moral appeal" approaches which teach students about the evils of use, and "affective education" programs which focus on building self-esteem, responsible decision making, and interpersonal growth are largely ineffective for reducing substance use. In contrast, approaches which include resistance-skills training to teach students about social influences to engage in substance use and specific skills for effectively resisting these pressures alone or in combination with broader-based life-skills training do reduce substance use. Curricula which focus on general life skills are typically longer than those which focus only on social resistance skills.

For more information, see the following: *Preventing Crime:* What Works, What Doesn't, What's Promising (1997). Office of Justice Programs and the University of Maryland, Department of Criminology and Criminal Justice

Web-site: http://www.ncjrs.org

Phone: 800.851.3420

Self-Esteem Enhancement Programs

(The following is an excerpt from Selected Findings in Prevention: A Decade of Results. Center for Substance Abuse Prevention, 1997, pp. 11-12.)

Background

Some addiction research of the 1960s and 1970s focused on the self-esteem portion of the self-concept model of personality, using such instruments as the Rosenberg Self-Esteem Inventory. Patients undergoing detoxification for alcohol or heroin dependence often revealed very low levels of selfesteem; theories were proposed to explain the apparent relationship between self-esteem and addiction. More recent analyses propose that the early studies were in fact developing a model of personalities undergoing detoxification rather than a model of a personality potentially susceptible to either addiction or substance abuse. Cocaine users in particular often exhibit unusually high levels of self-esteem before the onset of addiction. Nevertheless, many substance abuse prevention interventions continue to be based on the theory that self-esteem is a central issue to the onset of substance abuse (see, for example, Schroeder, Laflin, and Weis

Implication

A 1994 consensus panel convened by CSAP, after reviewing all available evidence, concluded that improving adolescent self-esteem is not necessarily protective against substance use and that poor self-esteem alone is not predictive of future substance abuse. Increased self-esteem probably should not be used either as a measure of the effectiveness of a substance abuse prevention effort or as an objective of prevention efforts. Alternate psychological measures that may be more useful to prevention include changes in such areas as positive self-concept, future orientation, family conflict, or self-perceived social competence.

Additionally, acquisition of competence in specific social and communication skills may have inherent protective value against substance rather than merely contributing to the problematic sense of self-esteem.

For more information, see the following: Selected Findings in Prevention: A Decade of Results. Center for Substance Abuse Prevention, 1997. To order a free copy, contact SAMHSA's National Clearinghouse for Alcohol and Drug Information (NCADI) Phone: 800.729.6686, and request publication order no. SMA 97-3143.

CSAP's Western Center for the Application of Prevention Technologies

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Julie Hogan, Ph.D., Director Kristen Reed Gabrielsen, M.P.H., Associate Director July 2002